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REPORT No.2

MODELLING CONNECTIONS in AGED CARE

REPORT on Stages 1-3



Australian Government

Department of Health and Ageing

**Development of an evidence based/best practice model
to facilitate quality clinical placements in aged care**

Robinson, A., Abbey, J., Toye, C., Barnes, L., Abbey, B., Saunders, R.,
Lea, E., Parker, D., Hill, O., Roff, A., Andrews-Hall, S.,
Venter, L., Marlow, A and Andre, K.

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This amended version of the report was corrected on the 20/3/08 to account for an error
identified in the number of student participants reported in the June 2006 version



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Glossary

- CACNSS Commonwealth Aged Care Nursing Scholarship Support Systems
- DON Director of Nursing
- RN Registered Nurse
- EN Enrolled Nurse
- PCA Personal Care Assistants
- RACF Residential Aged Care Facility
- UTas University of Tasmania
- QUT Queensland University of Technology
- UniSA University of South Australia
- ECU Edith Cowan University
- RCS Resident Classification Scale
- KCP Key Contact Person
- CF Clinical Facilitator
- CT Clinical Teacher

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Executive Summary

The Clinical Education Issue

That the issue of ageing is going to be high on the agenda of Australian governments and community interests for at least the next four decades is clear and well understood. Despite successive waves of government-driven reforms in financing, planning, provision and standards, extending now over two decades, we still have serious problems of staff recruitment and retention in this area, problems which, on present indications, are likely to peak at about the same time in the not-too-distant future as the demand pressures reach a new level of intensity. There is still a measure of uncertainty about some dimensions of the aged care workforce despite recent scholarly attempts to clarify the situation (Richardson & Martin, 2004).

However it can be agreed that rates of RN retirement and withdrawal for other reasons will exceed RN recruitment rates and thereby maintain pressure on the labour force supply side. That there are several causes of this declining trajectory is clear; that a widespread rejection of the actual or anticipated aged care clinical experience by student nurses is one of those several causes is equally certain.

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This is the second report to issue from the Modelling Connections project; and yet it needs to be remembered that it forms part of a growing body of Australian research conducted by this research team and other Australian nurse academics now extending over several years and all focused on the same set of issues associated with aged care nursing, especially as it is practiced in residential aged care facilities and taught in university schools of nursing (Happell, 2002; Pearson et al, 2001; Clare et al, 2003; Commonwealth of Australia, 2002; Parliament of Australia, 2002).

It is now approximately 5 years since two groups of nurse academics, one in Tasmania and the other in Queensland, each with strong local industry links, independently set out to discover why it was very hard to persuade the young undergraduate nursing students in their classes to consider aged care nursing as a career option. Each of the research teams began acquainting themselves with the available literature, methodically interviewing and surveying students and discussing the issues with their industry contacts and other stakeholders in the field. Both teams published work (Abbey et al, 2004, 2006; Robinson et al, 2004a, 2004b, 2005, 2006) on this problem before forming a coalition with other concerned researchers to begin work on Modelling Connections. While this was happening the Australian government commissioned a number of distinguished nurse academics to review the aged care research literature and curriculum and teaching materials. The point of this brief history is to remind the reader that the amount of literature digested, the number of cases examined, the variety of data accumulated, the lessons learned and the information disseminated is now beginning to mount up to the point where it seems reasonable to suggest that it is becoming significant by world standards.

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Stage 1 of Modelling Connections, funded by the Australian Government Department of Health and Ageing in 2005, appears to be the most extensive review of the Australian and international evidence on the clinical education issue yet published. Six hundred-and-seventy-one articles and reports were found *via* electronic searching and their abstracts examined to assess their relevance. The researchers thus reduced that number of items to a total of 173 to be read and summarised. This closer reading then reduced the number of items eventually selected for a full review to 121.

Finally the review concluded that

‘...taken overall, the literature on this sphere of education is abundant but often disappointing, and reliable evidence on the many difficult issues clinical education confronts is scarce.’

The report went on – and we emphasise it - ‘...none of the items examined contained or explicitly proposed a general model of how to conduct clinical placements in any sphere of nursing; and that such propositions as were advanced on this topic lacked the support of high level evidence and were generally narrow in scope’.

This provided the direction for the phase of Modelling Connections just completed and for those still in the planning stage. In particular, it led to an increased focus on the production of scientifically robust forms of evidence and the development and validation of the tools required to accumulate it. While such evidence is hard-won and takes time to acquire and verify, this is seen as by far the best way to command support for reform and to guide the direction of resources.

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This report makes the following points, covers the following activities and records the following outputs:

- A combination of disparate factors has separated the spheres of education and practice in a number of fields of professional training and in so doing made problematical their reunification. When, in the 1980s, the separation of the two spheres of education and practical experience was recognised as essential and implemented in the field of nursing, certain anticipatory measures were introduced to overcome any deficits due to the change. One of these was the clinical placement as we now know it.
- The perception of a gap between academic preparation and clinical preparedness has withstood those first-round re-unificatory measures and is now being recognised as a matter of concern to members of the public, government, the professions and students themselves.
- In the sphere of nursing, and most especially residential aged care nursing, the raising of the intellectual/educational capabilities of student nurses has outstripped the quality of the clinical education and training available to them in the RACFs, not due to any failure of will or lack of commitment on the part of those involved. The root of the problem appears to lie at the strategic level. The scope of coordination between the education institutions and the sector has not risen sufficiently to match the magnitude of what is inescapably a joint task; and the training capability of the residential aged care sector has not been able to expand to meet the new responsibilities placed upon it.
- In addition to any deficit that might be found – and this accumulating body of research gives good grounds for believing it has been found – there is a foregone opportunity to provide an experience of a kind that will encourage recruitment into the sector and at the same time foster the interdisciplinary training that is increasingly the hallmark of effective health service staff preparation.
- The report argues that the opportunity now exists to raise the training capability of the aged care sector by:
 - instituting or renewing, enlarging and enhancing partnerships between the industry and the education bodies;
 - moving the clinical placement experience, now something of a ‘cottage industry’, into the realm of structured, planned, resourced, education delivered through a collaborative quasi-contractual arrangement underpinned by an evidence-based model backed by careful planning and preparation, accountability mechanisms, appropriate staff selection and recurrent training regimes.

- In the course of gathering research resources the report demonstrated that the absence of quality assurance mechanisms and perhaps a set of guidelines or a standard operating procedures has allowed a severe discrepancy between staff and student accounts of the orientation experience to pass without notice or remedy, with consequent doubts raised about adequacy as a preparation for a positive industry experience. Such discrepancies mirror those reported in the Building Connections in Aged Care project (Robinson et al. 2004a, 2005), with respect to accounts on the adequacy of teaching and learning and suggest that aged care staff working with students have unrealistic perceptions of their impact.
- Workforce structure – it is predominantly non-RN, overwhelmingly part-time/casual, and suffers from professional isolation - probably imposes some limitations on the staff's training capacity, a limitation, which may be magnified by a lack of training in the skills of preceptorship and, often, a failure to define teaching and supervision as falling within the scope of duties.
- Qualitative data were used to provide another vantage point and to probe deeper than is possible using quantitative methods alone. Themes anticipated in the light of the broad literature review appeared in the tape-recorded comments from the groups. The inclusion criterion for themes picked up in this report was that, in the opinion of independent judges, the matter had arisen clearly in the recorded comments from every State. Student perceptions and concerns were our first priority. Anxiety about what might be in store, a sense of shock and confusion about the peculiarities of nursing older, often confused people and a failure to understand or see the distinctive lessons that might be learned in the setting: all these were represented in student feedback, findings in accord with the Building Connections project's conclusions and echoing the international research on the subject. Staff had their own apprehensions, again indicating a lack of adequate preparation for the experience and the role in which it casts them. Among the recorded themes were: awareness of the added pressure on what they already see as a demanding workload in an often stressful workplace; concern about their fitness for the task of mentoring young undergraduates with a broader academic preparation in nursing than their own; occasional unease, in the case of PCAs, about status differences; a little defensiveness about the poor image of aged care nursing within the profession, caught in talk about what is and what is not 'real nursing'; and feeling somewhat torn between the demands for their attention from both students and residents, whose reaction to the visiting students is also of importance. It is fair to conclude that, beneath what may seem to some to be a rather straight forward encounter with clear objectives and limited demands, there is a great sense on the part of both students and staff of unease, stress and anxiety, leading sometimes to a slightly defensive, distancing reaction and sometimes to a sense of inadequacy. Preparation and regular ongoing debriefing, for both staff and students, as the experience unfolds seems to be clearly indicated, but, in the absence of a model or guidelines, it appears not to be well recognised or implemented.
- The report includes a necessarily detailed account of the extraordinary work entailed in developing a student activity log, a testable and replicable tool to accurately record the activities carried out and the source and intensity of the supervision provided to each student during aged care clinical placements. The tightly structured process required to meet the highest scientific standards for reliability and validity, carried out with the involvement and advice of internationally recognised experts in tool development is fully recorded and open to scrutiny. The team believes this is likely to attract significant interest when published in its final form. It is in any case a very important part of any attempt to facilitate quality clinical placements in aged care as it provides an objective assessment of students experience which can be used to inform interventions designed to maximise appropriate learning outcomes.

Executive Summary

- Finally, a draft evidence-based/best practice model (EB-BPM) is presented in this report and the team believes it is now at a stage where trialling can begin. Within the report an accompanying Manual explains the rationale and objectives of the EB-BPM. This section opens with a note on the structure of the document and how to navigate through it, making appropriate connections. In summary: there are four distinct, sequenced steps in the overall process:
 1. 'Preconditions' refers to preliminary steps that are recommended as necessary to forge a new partnership between the industry and the schools of nursing in the preparation and accreditation of student nurses;
 2. 'Preparation' deals first with the work that must be done with students in the university before they begin their clinical experience; it then focuses on the work that must be done within the RACFs with management, staff, residents and their families;
 3. 'Support on the site' covers the measures that must be implemented and the climate that must be cultivated if student and staff collaboration in practice and learning about practice is to be as fruitful and stimulating as it could be. This includes 'de-briefing', a stage that has a vital part to play in assisting the students and staff to find meaning in their experience and to reflect on how that meaning may relate to any preconceptions they may have had.
 4. 'Evaluation' is a key step in the process of continuous quality improvement inasmuch as, effectively carried out, it gives every participant a chance to make known their assessment of the experience and the grounds on which that assessment rests. Ongoing evaluation is integral to the model and its assessment of how successful implementation has been as variables will change across facilities and across time.

Under each of those four general headings is a list of particular actions that must be taken in pursuit of the general objective. Items in those action lists carry a numeric and alpha identifier keyed to the evidence base which concludes each section of the Manual.

The report closes by offering a number of recommendations (see below) and the team commends them to the reader.

Recommendations

Issues

- Despite being a key cost centre of undergraduate nursing education there are ongoing problems associated with the lack of focus on clinical education & pedagogy in aged care settings.
- Consequently, there is no high level evidence base to inform the practices and organisational arrangements that underpin clinical education in aged care.
- The situation reflects the status of clinical education as a cottage industry with an associated poor student experience of aged care nursing practice.
- This is especially problematic given the longstanding and seemingly endemic problems of recruiting nurses in aged care and the association between students experience in clinical placements and career intentions (Robinson et al., 2004b, 2005, 2006).
- There is an urgent need to develop a robust and transferable model to facilitate quality clinical placements in aged care.
- The establishment of teaching nursing homes is central to supporting the implementation of the model and the development of an associated evidence base.

Recommendation 1

That the Australian Government Department of Health and Ageing fund a project to test the draft evidence-based/best practice model (EB-BPM) and produce high level (Level II) evidence on its applicability to residential aged care settings in Australia.

Recommendation 2

That the project designed to test the draft EB-BPM should produce a toolkit to facilitate its implementation by aged care providers and university staff. The toolkit should include:

- resources for pre placement preparatory sessions for students;
- a template for mentor/preceptor preparatory sessions; and,
- a range of validated instruments to be made available for use by RACFs and universities to evaluate the effectiveness of their implementation of the EB-BPM.

Recommendation 3

Following completion of the project to test the draft EB-BPM, that the Australian Government Department of Health and Ageing fund a project to support its implementation in aged care facilities across Australia. Key strategies in this implementation process should include:

- Development of an interactive website that will allow queries and suggestions for implementation from the community of practitioners in residential aged care as well as for the dissemination of information about the EB-BPM.
- Dissemination of information about the EB-BPM via a newsletter, essential for staff members who do not have internet access or skills to learn about its operation.
- Establishment of a “hotline” dedicated to responding to queries about the EB-BPM’s implementation.

Recommendation 4

To facilitate uptake of the EB-BPM and the development of quality clinical placements in aged care, in liaison with key stakeholders and champions, the Australian Government should:

- encourage programs and events that focus attention on the issues associated with clinical education in aged care settings;
- encourage the formation/review and enhancement of high level aged care industry-university partnerships aimed at fostering more formal, more comprehensive collaboration in the planning, provision and evaluation of aged care clinical placements;
- encourage, in consultation with the universities and the residential aged care sector, the adoption of the EB-BPM in aged care to provide a supportive context for the implementation of its reform initiatives in the curricular sphere;
- support the development of an ongoing research evidence base on which to base clinical practice education in aged care;
- encourage the development of a Quality Assurance culture with respect to clinical education in aged care settings;
- facilitate discussions with university schools of nursing, state nursing registration boards and professional peak bodies aimed at moving toward the introduction of strong; accountability mechanisms in relation to clinical education in aged care;
- assess support across the healthcare professional peak bodies for the development and recognition of teaching nursing homes in conjunction with the Aged Care Accreditation Agency accreditation.

1. Background

While the aged care industry is a major employer in the Australian economy (Hogan 2004), there are longstanding problems with the recruitment and retention of nurses in the sector. As the National Review of Nursing Education 2002 (Department of Education; Science and Training and Department of Health and Ageing 2002) suggests, recruiting and retaining nurses in aged care is 'the most significant issue' related to the aged care workforce. Ongoing problems include: the part-time nature of the workforce; the context of limited professional engagement for nurses working in the sector; the lack of an evidence base for training and curricula; and deficiencies in the operative philosophies and organisational capacity within and between the major institutions involved in the process of nurse training. The result is an environment where undergraduate nursing students struggle to come to terms with the reality that is aged care nursing.

Such concerns underlie attempts by the Australian Government Department of Health and Ageing (DoHA) to promote aged care to student nurses as a viable career option. This promotional effort is apparent not only in the Commonwealth Aged Care Nursing Scholarship Support Systems (CACNSS) program, but also in efforts to promote aged care among undergraduate students through funding the development of a principles paper which outlines 'desirable aged care content for inclusion in undergraduate nursing curricula' (Queensland University of Technology 2004).

In these circumstances the focus on developing quality clinical placements in aged care and an evidence based /best practice approach to undergraduate nursing students' clinical placement in the sector has never been more relevant. That is the chief objective of this report and of the larger project from which it springs. Before proceeding to outline the research and report the findings of these phases of the Modelling Connections undertaking, however, it is important to put our central problem into a larger perspective, not least because, narrowly conceived it will not be resolved.

The origins of the clinical education issue

It is likely that no previous period of our history has seen the professionalisation of as many occupational roles as occurred in the second half of the twentieth century. This process was first necessitated and then accelerated by the rapidity of the development of technologies of information storage, retrieval and communication. The impact of these influences was compounded by associated phenomena such as globalisation and changing approaches to law and liability. Workplace roles that formerly had quite different, somewhat fixed characteristics, with associated cultures, have been incorporated at an unprecedented rate into the sphere of intellectual labour, characterised principally by the need for qualified practitioners to be familiar with swiftly evolving bodies of technical knowledge, and to master the requisite mental skills of inquiry, retrieval, comparison, critique, communication, analysis, judgement, application and review.

Society's chief cultural and organisational response has been to specialise. A finely graded division of labour, primarily now by function allied to training and accreditation, rather than, as it formerly was, by hierarchical status, has grown up. Part of this has been a separation of the bodies of knowledge conceptualised as 'theory' and 'practice'. Where once these were located within the individual mature practitioner and passed on to novices by direct tutelage and emulation in the worksite, the matter of combining the two, now in the possession of different branches of each of the professions, has become a knotty problem in organisation and epistemology which inhabits its own public space. Many benefits have certainly resulted from the trend towards specialisation, but, on the other hand, a disconcerting number of problems and new challenges have been created or made apparent, or found to be less tractable than was anticipated when 'theory' and 'practice' were divorced.

One of these problems is what we will term the modern form of the ‘clinical education issue’: how best to effectively and efficiently transform an academically prepared neophyte, at home in a higher education context, into a confident and quasi-independent practitioner with the practical skills and judgement needed to carry out the profession’s broad body of core functions safely and intelligently in at least the most common contemporary practice settings.

This project has traced the emergence of the modern form of the ‘clinical education issue’ in nursing back to these same roots, settling, for convenience, on the transfer of nurse education to the tertiary education sector as its most noticeable birth date, the moment when the skeins of experience which must somehow be woven together to create professional competence were most decisively separated and allocated to different periods and locations.

The dimensions of the clinical education issue.

It is important, however, not to suppose that the issue framed in this manner is peculiar to the health sciences, let alone nursing. It has presented itself to practitioners and educators in, for example, the fields of law, journalism, architecture, psychology, veterinary studies, music, education and accounting, where it has been present in one form or another for a long time; and in other fields such as management, or information technology and communications, where it is a recent arrival.

There are several reasons for wishing to draw attention to the breadth and scale of the ‘clinical education issue’ and to ensure that it is properly conceptualised within its context. First, to point to the commonality of the activity in which all these students and fully-fledged professionals are engaged makes it easier to see what they are doing as a vital, specialised segment of a major national education and training enterprise involving not only large costs but also outcomes significant in determining national performance in a range of economic, social and industrial spheres. One has only to consider the number of people so engaged each year and the outlays involved to demonstrate the need to ensure that ‘clinical education’ is carried out at the highest levels of achievement, efficiency and effectiveness.

A second reason to point out the commonality of the activity is to open our search for improvements in nursing’s training capacity to lessons that may already have been learnt in other fields, or, conceivably, to open the way for the transfer of lessons about to be learnt in nursing to other fields. A cautionary note is necessary. Seeing the common elements does not posit the existence of a single best approach of the ‘one size fits all’ kind. To note the commonalities is not to ignore the significant differences and variations that will be found to be influential, through their presence or absence, their strength or their weakness, in different fields of endeavour. Having conceptually aggregated the disparate activities that make up or constitute ‘transitional education for neophyte professionals’ or ‘clinical education’, and gained an impression of their scale and importance, we are led to examine the institutions, instruments and cultures that constitute each particular field of learning and training to assess their adequacy to the task set for them.

While the necessary reform activities will all take the form of ‘capacity building’, the specific reforms required can be expected to differ from field to field. In our particular sphere of inquiry the question becomes: how well prepared, equipped, and motivated are the university schools of nursing and the aged care sector to collaborate in defining, creating, operating and maintaining a range of compelling, high quality clinical placement experiences for enthusiastic, young, well-schooled, aspiring professionals – members of a generation much better attuned than its predecessors to the importance and appeal of life-long learning in the cause of continuing professional development, to the reliance on evidence as the foundation of action, and to the practice of inquiry and critique in the workplace?

The question needs to be in the forefront of our minds, providing us with a measure against which we can assess whatever is uncovered in the research and, accordingly, what it is that we should be aiming at.

The final reason for wishing to construe our problem broadly is to show that the ‘clinical education issue’ would continue to be of the first importance even if there were to be no labour shortage in any of the professional fields mentioned above.

There has been a recent upsurge of critical and reforming activity in relation to ‘clinical education’ in different disciplinary contexts. The issue of ‘clinical education’ or ‘transitional education for the professions’ that is being urged in this brief section may emerge as the next realm of national educational reform. If so, planning will be needed to give this movement the momentum and impact it needs to have. Linking funding to demonstrated advances in collaboration across outmoded organisational and professional boundaries, role flexibility, greater attention to training, consumer involvement, quality assurance and improvement mechanisms, together with specified accountability processes – all these are likely to be required. This project sees itself as an early part of that embryonic movement.

As the project’s systematic review discovered, interesting and well reported work has been done and is continuing in the use of various technologies to provide students with ‘virtual clinical experience’. Although the results obtained so far have been mixed, the Modelling Connections project team welcomes such work, while maintaining that its potential sphere of application to aged care nursing is more limited than is the case in some other areas of healthcare education. The deficits in the training experience provided to undergraduate nurses in aged care settings have little to do with any failure to transmit tightly defined techniques within a well-functioning clinical setting already supported by an advanced evidence base – the type of situation in which real-time simulations are most appropriate.

The problem in residential aged care is broader and the solution must be too. In fact, the problem in aged care nursing is itself the opportunity: to launch a transformational strategy in which the context is as much the target of the innovative input as are the students. That is the goal at which this project is aimed: the need to provide more stimulating and fulfilling clinical experience in a fully attuned, educative and supportive high quality aged care setting.

Having said all that, it remains the case that Modelling Connections was sparked off by the immediate and foreseeable difficulty in recruiting and retaining quality staff with adequate training and commitment in the field of residential aged care nursing. It has as one of its objectives the conceptually distinct business of raising the capacity of aged care nursing in particular to train, recruit and retain enthusiastic and competent practitioners and specialist educators. The need for this is obvious, not only in Australia but in comparable countries elsewhere. As in other areas of scarcity affecting the healthcare workforce, the likelihood of a continued rise in pressure to avoid further worsening the current global maldistribution of skilled health workers by resort to ‘poaching’ from the less developed world will translate to pressures to ‘grow our own’.

History of the Modelling Connections in Aged Care Project

In April 2005 a proposal to conduct a four state demonstration project to develop a draft evidence-based /best practice model to facilitate quality clinical placements in aged care was submitted to DoHA. The proposal was based on work that had been undertaken with UTAS and QUT. The proposal put forward suggested 7 stages as follows:

- Stage 1 - Systematic literature review
- Stage 2 - Consultation with Stakeholders and the collection of base line data on the participating RACFs
- Stage 3 – Development of draft evidence based /best practice model to facilitate quality clinical placements in aged care

- Stage 4 – Multi-State controlled trial to test applicability and further develop draft evidence based /best practice model to facilitate quality clinical placements in aged care.
- Stage 5 – Revision of the draft evidence based /best practice model to facilitate quality clinical placements in aged care
- Stage 6 – Web based dissemination and evaluation of model among multiple users
- Stage 7 - Final project report

DoHA's decision was to fund the first three stages of this project. In retrospect this decision seems to have been an excellent one, as the data that was produced through the systematic review and our subsequent research has led to different conclusions about what is needed in the further stages, compared to those submitted in April 2005. In the first instance the conduct of project Stages 1-3 aimed to: (i) develop a comprehensive account of the evidence underpinning the conduct of clinical education in aged care; (ii) determine the degree to which the findings of the Building Connections in Aged care project (Robinson et al., 2004a, 2004b, 2005, 2006) were representative of the status of aged care clinical placements by conducting fieldwork across four States, and; (iii) to draw on all the available evidence to develop a draft evidence-based/best practice model of quality clinical placements in aged care.

Stage 1 – Systematic Literature Review

This stage of the project was undertaken in late 2005 and the report, 'Clinical placements for undergraduate students in aged care – a systematic review', was presented to DoHA in January 2006. The primary objectives of Stage 1 were:

- (i) to identify, summarise and evaluate studies which have examined the experiences of undergraduate students, teachers, site staff and patients during clinical placements
- (ii) to do this in a way that provides maximum assistance for the research team carrying out the later stages of the larger project.

The focus was on studies published in the English language during the period 2000 - 2005 and related to undergraduate nursing students' clinical placements. Occasional reference was made to earlier publications where it seemed necessary or useful. The project team combed a wide range of databases containing journal articles and reports in the fields of nursing, general health sciences and service delivery, education, aged care, psychology, other social sciences, quality assurance, treatment guidelines, and systematic reviews. This was followed by hand searching selected journals and the reference lists of numerous reports and investigations, using as discriminators the same keywords and terms as used in the database searches. This yielded numerous additional items, some of which were published very shortly prior to or contemporaneously with our investigation.

A total of 617 items were identified as matching the nominated MESH terms and keywords. The titles and abstracts of these items were examined to assess their relevance. Four hundred and eighty-four items were rejected at this stage and 133 were retained. Of these, 22 items were duplicates, leaving 111 items from these searches. Additional hand searching found another 62 items.

Therefore the total number of items selected for a full review was 173. Four reviewers then collaborated to read and rate all retained items against the criteria set out in the 'Data rating and extraction sheets', with each item reviewed independently by two or three and sometimes, where it seemed necessary, four reviewers. A further 52 were rejected during this stage, leaving a final selection of 121 items.

The focus and reliability of evidence and findings that emerged from the literature under review did not provide a foundation for offering recommendations of the kind that constitute the usual output of a systematic review. This is not to say that the review of the evidence has yielded nothing of

value to the larger objective of this project. The identification of important but under-researched areas is one valid outcome of a systematic review; and a sure sense of the quality of evidence available and the balance of expert opinion is another. The review yielded a clearer view of the problems any sound model of clinical education would need to surmount. The review team, in declining to offer recommendations, took the view that a summary of the informal conclusions it had reached and an outline of remaining issues would be its best contribution to the longer-term aims of the project. We reproduce what the project team had to say in the January 2006 Report (p.4).

The systematic review revealed that, taken overall, the literature on this sphere of education is abundant but often disappointing, and reliable evidence on the many difficult issues clinical education confronts is scarce.

There is no high level experimental evidence bearing on the research questions addressed in this review and there is a dearth of well-supported qualitative evidence available. On the other hand, there is a significant concurrence of expert opinion. Eighty-six per cent of the items that met the criteria for inclusion were classified as resting on qualitative studies or the opinions of experts in the field, with the latter type making up just under one-third of all included studies.

We found that few items;

- focus on the specific circumstances and needs of aged care nursing
- reported studies/gathered data from across national/cultural boundaries
- reported studies conducted in Australia
- were multi-site studies. Where they were they usually involved different groups with overwhelming similarities (eg. students of similar or identical courses at nursing schools within a region, without carefully specifying any differences or the likely impact they might have on the study's outcome)
- involved careful comparative elements, even pre- and post – testing of the same group being rather rare
- displayed sufficient 'scientific rigour' as that is conventionally understood in the systematic review literature, with only one item rated Level II and a total of only 13% of all the evidence being rated in the level II – Level IV band.

This report shows that none of the items examined contained or explicitly proposed a general model of how to conduct clinical placements in any sphere of nursing; and that such propositions as were advanced on this topic lacked the support of high level evidence and were generally narrow in scope.

To be more specific, there were no models advanced for the conduct of undergraduate nursing clinical placements in the aged care setting which, at any level of evidence, could reasonably be described as being evidence based. Indeed, there has been no comprehensive assembly and analysis of the materials and practices necessary to establish what best practice is in this particular area of education. More especially, there has been no attempt to develop a model that takes comprehensive account of the evidence of possibilities and pitfalls that has accumulated in the literature. There has been work on stating underpinning principles and devising mechanisms that would be required for such a model and there have been some very valuable steps taken towards constructing the foundations for the development of such a model. Much of this work has been done in Australia and has appeared in the form of major reports of inquiries or research commissioned by government.

That said, the work of constructing and validating a comprehensive model is still to be done despite the evident gains that would accrue from success in such a venture. The volume of literature from around the world is quite sufficient to show that such a model would be received with great interest.

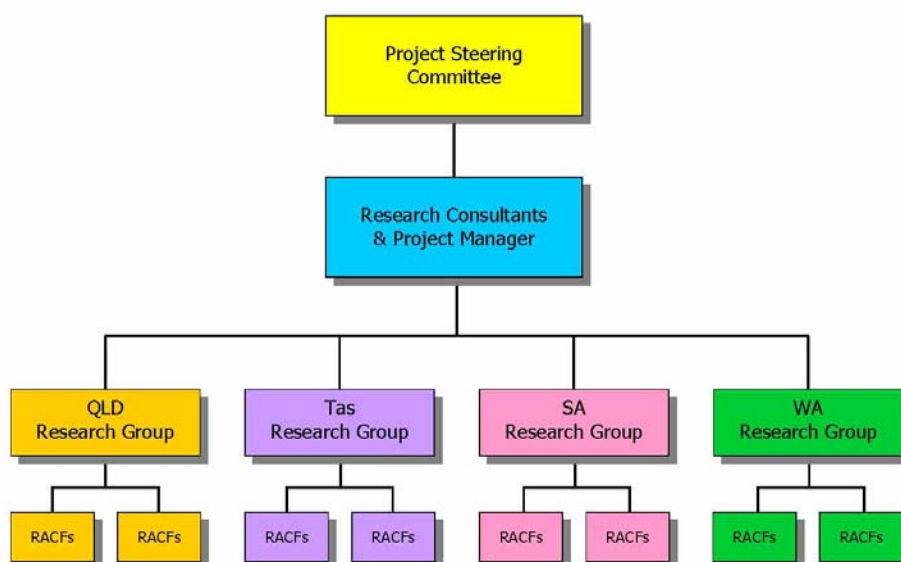
The core finding from the literature review '... that none of the items examined contained or

explicitly proposed a general model of how to conduct clinical placements in any sphere of nursing; and that such propositions as were advanced on this topic lacked the support of high level evidence and were generally narrow in scope', provided the direction for the phase just completed and for those still in the planning stage. In particular, it led to an increased focus on the production of scientifically robust forms of evidence in the belief that only such evidence will generate the persuasive power required to command support for reform and to guide the direction of resources.

Management of Stages 1 - 3

All three stages were overseen by a Steering Committee comprising the project investigators listed, key stakeholders in aged care and representatives from the DoHA. The Steering committee met 6 monthly to consider progress in the project.

Figure 1: Project Structure



The meetings of the Steering Committee were held *via* teleconference. The first one was on 25th October 2005 where an update on the progress of the systematic review was discussed, as well as early reports on collection of the qualitative data. The second meeting, on 20th February 2006, discussed the completed systematic review and some of the findings as well as reports on progress of data collection. A third meeting, held on 8 May 2006, discussed an overview of the chief investigator meeting decisions, the data and findings, the draft model and proposal.

Ethics Approval

Approval to conduct the project was obtained prior to commencement from the ethics committees of the respective universities. They are, the University of Tasmania's Human Research Ethics Committee (Tasmania) Network (Ethics Ref: H8540), the Edith Cowan University Human Research Ethics Committee (Ethics Ref: 05-168 TOYE), Queensland University of Technology's Human Research Ethics Committee (Ethics ref: 4258H) and the University of South Australia's Human Research Ethics Committee (Ethics protocol P201/05). Participants read an information

sheet containing details of the project and signed a consent form prior to participation. (Appendices A & B)

Project Timelines and Milestones : Stages 2 & 3

All the project timelines and milestones, as set out immediately below, were met.

Table 1: Timelines and Milestones

Milestones		Deliverable	Date
Sept 05	Ethics submission	Ethics approval	Sept 05
Oct. 05	Teleconference with steering committee	Confirmation of Progress Report	Oct. 05
Oct 05- Mar 06	Stage 2 Consultation with Key Stakeholders: Focus Groups (X 6 per state) and Surveys (demographic information and scope issues in participating facilities)	Surveys undertaken, focus groups and interviews conducted.	Oct 05-Mar 06
Feb 06	Teleconference with steering committee	Report on data collection	Feb 06
April – June 06	Stage 3 Development of Draft Model from the findings of stage one and stage two Trial Revised Supervision and Activities Placement Log	Draft Best Practice Model Progress Report	June 06
June 06	Teleconference with steering committee	Report on final report	June 06

Method: A Short Introduction

This study collected quantitative and qualitative data across four Australian States in late 2005 and early 2006 from groups of the principal participants in the provision of clinical education programs to student nurses. Each of the four State-based research teams identified the facilities to be included, gained the consent of the management, staff and students involved, and administered questionnaires designed to elicit the required information. The participants included were:

- 53 students from four different university nursing schools who had completed clinical placements in a dozen different RACFs
- the Directors of Nursing (DONs) of those twelve RACFs
- 55 Registered Nurse, Enrolled Nurse and Personal Care Assistant (RN/EN/PCA) mentor/preceptors from those RACFs.

The primary requirements for inclusion of any RACF were that it had been involved for some time in hosting clinical placements for nursing students and that it be able and willing to participate in

the research project. The details of the recruitment process differed only slightly from State to State, but they are detailed for the sake of completeness.

Recruitment Processes

Recruitment of Tasmanian groups

All RACFs in the two major cities of Tasmania (Launceston and Hobart) who had not been involved in previous research conducted by the Tasmanian team and who were to have University of Tasmania student nurses on placements in second semester 2005 were invited to participate in the study (n=6). One month prior to the nominal/focus group interviews, members of the research team met with all students who were going on placement in those facilities, in order to inform them of the study and obtain consent. Fourteen of the 17 attendees at this meeting consented to participate in the project. Those staff who were involved in supporting these students at the RACFs were invited, *via* their DONs, to participate in the study. Attempts were made to include RNs, ENs and PCAs in mentor/preceptor nominal groups as recognition of the role that each staff category plays in supporting students.

Recruitment of Western Australian groups

In Western Australia a similar process was undertaken. However in this case student participants were recruited from a list of names obtained from the Clinical Coordinator and invited to participate via telephone. An information sheet was subsequently mailed to students. As in Tasmania, participation of mentor/preceptors was organised through RACFs DONs. Information sheets were subsequently posted out to DONs for distribution to staff. In order to recruit DONs, a list of RACFs used by Edith Cowan University was obtained from the Clinical Coordinator. DONs were contacted by phone, with information sheets e-mailed to participants.

Recruitment for Queensland groups

Two Queensland RACFs participated in the study upon the invitation of one of the Chief Investigators. Participation was based on their willingness, availability and regular facilitation of QUT student placements. Students were recruited in a similar manner to the WA cohort except they were invited to participate by mail. Mentor/preceptor and DON recruitment mirrored that of WA.

Recruitment of South Australian Groups

Two South Australian RACFs participated in the study on the basis of their ongoing involvement with the school of clinical placements. Recruitment of students, mentor/preceptors and DONs mirrored WA and Qld cohorts.

Data Collection Methods

A range of data gathering techniques were used – questionnaires, a student activity log, nominal groups and focus groups – to allow methodological triangulation of data, important in enhancing the validity of the study.

A total of 120 respondents completed a range of questionnaires adapted from the Building Connections in Aged Care project and developed with the aid of an expert panel. Additionally, a facility information questionnaire (Appendix 1) was completed by the DONs of RACFs who had RN/EN/PCA mentor/preceptors and students involved in the focus/nominal groups. These data were gathered in a form that allowed statistical analysis and provide the foundation of Chapter 2 which follows immediately.

Chapter 1: Background

These questionnaires were in almost all cases completed during the respondents' attendance at organised focus/nominal group discussions conducted separately with each category of participants: students, DONs and nursing/care staff. Data gathered through the focus groups and nominal groups allowed qualitative analysis and this material forms the basis of Chapter 3.

These discussion sessions extended over a little less than two hours and were divided into two parts. The first, shorter part, was conducted as a 15 minute focus group discussion followed by a longer segment, lasting between 1.5– 2 hours and conducted using the nominal group technique.

The student activity log is an instrument developed in the Building Connections in Aged Care Project (Robinson et al. 2004b, 2005) to gather data on how students spent their time while on placement and how and by whom their supervision was provided. It was completed by 53 students. It is included in this report primarily for its methodological interest and will be reported quite separately in Chapter 4 as it is being tested and validated for use in successive Stages of the Modelling Connections project.

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This section of the Report, on methods is intended as an overview only. A fuller outline of any relevant theoretical material, details of the data gathering techniques, the content of the questionnaires and discussions, as well as the group numbers, will be provided immediately prior to the reporting and analysis of each of the types of data collected.

2. Quantitative data – setting the context

Commentary

The information reported in the first part of this section was gathered for the purpose of establishing as clear a picture as was practically possible of the participating institutions, their managers and staff, and the number and disciplines of the students who had undertaken clinical placements within them.

It was neither practicable nor necessary that the facilities included in the sample be statistically representative of the approximately 3000 accredited RACFs in Australia. Our goal was an in-depth study of the experience of enough undergraduate nursing students enrolled in enough different universities who had undertaken clinical placements in enough different facilities in enough different states to give us some grounds for confidence that what was found in the research would be likely to be found in any similar inquiry in a selection of other facilities around Australia.

Nonetheless, as a discipline, the research team has remained cognisant of relationships between the characteristics of the facilities in which the study is ongoing and those of Australian RACFs overall, and has sought to assist the reader to see our findings in the broader context. The objective now is to report that data as concisely as possible, with comparisons where appropriate to national averages or other benchmarks, before proceeding, in the later part of the chapter, to an analysis of what the staff and students told us about what key information they believe was provided to the students as part of the orientation process.

Quantitative Data Collection

Student nurses, RN/EN/PCA mentor/preceptors and DONs of RACFs completed a range of questionnaires as a part of the data collection procedures employed in the project. As stated previously, all questionnaires were adapted from the Building Connections in Aged Care project, with an expert panel providing feedback on their development. They included;

- **a student profile questionnaire** completed by students, which contained information related to age, prior experience in aged care (Appendix 2);
- **a RN/EN/PCA profile questionnaire** which contained items on age, qualifications, experience in RACFs, educational preparation and experience as a support person or preceptor (Appendix 3), and ;
- **a orientation checklist with ‘yes’, ‘no’ or ‘unsure’ response** options completed by students (Appendix 4), mentor/preceptors (Appendix 5) and DONs (Appendix 6). These obtained information on the presence of a formal orientation program in the facility and on various aspects of orientation, such as whether students were introduced to specific staff (e.g. DON, reception staff) or informed where to access a telephone or have a meal break.
- **a facility information questionnaire** was completed by the DONs of RACFs who had RN/EN/PCA mentor/preceptors and students involved in the focus/nominal groups. It contained items on facility size and type (high vs low care), staffing profiles on each shift, position description of staff, extent of access to paramedical, medical and recreational staff expertise, and number and type of students in the facility in the previous year.

Quantitative Data Analysis

Individuals were not identifiable. Raw data from the questionnaires were entered into SPSS statistical software (vsn 13, SPSS Inc., Chicago, Illinois) for analysis. At the completion of data

entry, frequencies for each variable were calculated and any apparent anomalies in the data entered were checked against the original questionnaires. Analyses included basic descriptive statistics such as frequency of response and cross-tabulations for measures of association using the Gamma coefficient with a significance level of 0.05.

Profile of the RACFs involved the project

Twelve facilities spread across four States were recruited to the study. Six of the RACFs, half of the total number of participating facilities, were in Tasmania, and the other three States each recruited two facilities. The data arising from the study is more broadly based or representative than that may suggest. Each of the Tasmanian RACFs accommodates fewer nursing students at any one time than happens in the other States in the study and therefore more of them needed to be included to match the number of staff and students recruited in other states. The point is made clear by the data in the following table (Table 2 below) showing the number and state of origin of staff and student respondents.

Table 2: State of origin of staff and student respondents

STATE	SA	TAS	WA	QLD	TOTAL
STAFF	9	15	17	14	55**
STUDENTS	13	14	17	9	53

**In some cases this group of staff, comprising RNs, ENs and PCAs, was supplemented by 12 DON respondents, all of whom were RNs, thus bringing the maximum number of respondents to 120. .

Data about the facilities themselves were collected from DONs *via* a questionnaire. Australia's RACFs are owned and operated by charitable or religious bodies on a not-for-profit (NFP) basis; or by private for-profit operators; or by government. The ownership and operating basis of the three thousand or so accredited RACFs in Australia is shown in the Table 3 below, as is the comparable data for the RACFs included in the sample.

Table 3: The ownership of Australian RACFs compared to our sample.

	CHARITABLE/NOT FOR PROFIT	PRIVATE FOR- PROFIT	GOVT- OWNED
*AUSTRALIAN RACFS	65%	25%	10%
STUDY SAMPLE	91%	9%	0

* Source: Hogan, 2004.

The dozen RACFs included in the sample had a total of 1042 beds, and the arithmetical mean size was 87 beds; whereas the AIHW (2005) considering all Australian RACFs as a whole, records the average number of places in a facility as 53.

The mix of larger and smaller RACFs across Australia and in the study sample is compared in the following table (Table 4 following).

Table 4: The size of Australian RACFs compared to our sample.

	SMALL RACFS	MEDIUM SIZE RACFS	LARGE RACFS
	(40 OR FEWER BEDS)	(41 – 60 BEDS)	(61 OR MORE BEDS)
*A RACFS	41.1%	30.7%	28.1%
STUDY SAMPLE	9%	25%	66%

*Source: AIHW Residential Aged Care in Australia 2003-04

On that basis it would appear that our sample covers the spectrum as far as size goes but our sites are usually larger than the national average.

Compared to the whole Australian industry profile the study sample was twice as likely to offer a mix of both high and low-care beds. (Table 5).

Table 5: High care, low care and mixed care: Australian RACFs and our sample.

	Low care beds only	Mixed, both low & high care	High care only
*Australian RACFs	33%	33%	33%
Study sample	17%	66%	17%

*Source: AIHW Residential Aged Care in Australia 2003-04

The size and care-mix data suggest the unsurprising conclusion that the RACFs included in the sample were probably selected with a view to offering a wider range of experience of different levels of care than a random selection from the Australian industry would probably have achieved. Given the training purpose of the clinical coordinators' selection, that might have been expected.

On a comparison of the residents' level of dependence as measured by the RCS scale it would seem that our sample, with about half the total number of beds classified as high care, falls below the Australian sector-wide figure of about 66% (AIHW, 2005). This comparison, and the earlier one concerning average facility size, must be treated with caution however, as variables such as mix-of-care levels are known to be rough approximations because the ageing-in-place principle often leaves classifications lagging actual levels of care being administered within a particular facility and across the system as a whole.

Figure 2 below uses data supplied by the twelve DONs to create a picture of the nursing and care staff profile in the average facility from among those sampled. Our sample spans the spectrum from quite small to quite large facilities, and so caution is appropriate for the usual reasons associated with averaging across a diverse sample. Obviously the staff numbers in a facility will vary in some sort of relation to bed numbers, but the relative representation of the different grades of staff is probably reasonably indicative of standard practice across the sample and, in the judgement of highly experienced aged care specialists, probably across the sector.

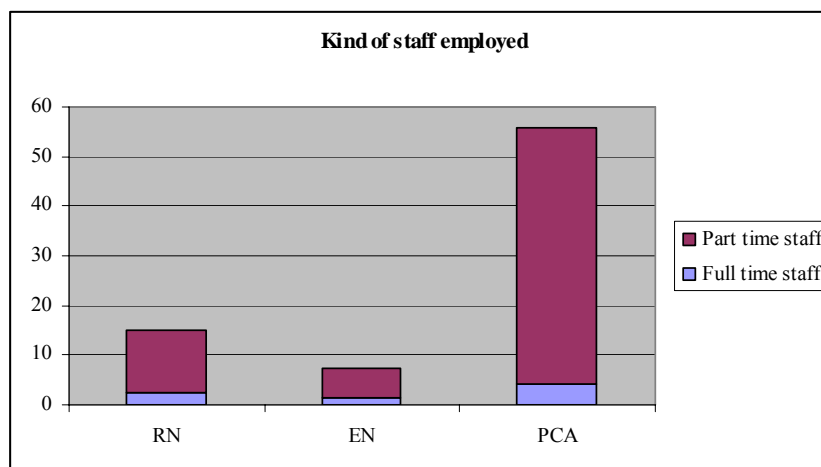
Figure 2: Profile of staff employed

Figure 2 above displays two key features of the facilities' staff profiles, interesting in the light of their role as training facilities for students studying to become registered nurses. The majority of staff are PCAs and the majority of all staff work part-time.

We also gathered data on the composition of a typical shift for both afternoons and mornings on both weekdays and weekends. There was not a great deal of variation across the day or across the week, with the average weekday shift profiles looking like this (Table 6).

Table 6: Representative shift profiles: Staff on duty.

Weekday morning shift		Weekday afternoon shift	
RN	2.83	RN	1.92
EN	2.17	EN	1.33
PCA	10.38	PCA	7.96

These figures are roughly equivalent to those reported by Richardson and Martin (2004). Richardson and Martin's (2004) report states that in 2003 there were 116,000 direct care employees, of whom 25,000 were RNs, 15,000 ENs and 67,000 PCAs in RACFs (p.1,2). RNs consisted of 21.6%, ENs 13.0% and PCAs 57.1% of the total aged care workforce.

There are two remaining features to be covered in this brief portrait of the participating facilities, and the first is the range of other health and health-related services available within them. DONs were asked about access for residents in their facilities to a wide range of primary and specialist health care services and then, separately, about the amount of access available. The data was somewhat unclear in respect of the amount of access but it can safely be said that some of the RACFs, usually a third or more of them, were able to provide residents with some access to the range of services listed in the table (Table 7 following). The fraction shows the number of the twelve RACFs able to provide such access and the percentage this represents is shown in the next column. The most commonly-available services appear near the top of the table with the remainder in descending order.

Table 7: Access to other healthcare or health-related staff

Do residents in your facility have access to a:	Yes	
	Count	%
Physiotherapist?	11/12	91.7%
Diversional Therapist?	11/12	91.7%
Podiatrist?	9/12	75.0%
Dietician?	7/12	58.3%
Speech Therapist?	6/12	50.0%
GP?	5/12	41.7%
Continence Specialist?	5/12	41.7%
Palliative Care Specialist?	4/12	33.3%
Occupational Therapist?	4/12	33.3%
Psychogeriatrician?	3/12	25.0%
Hearing Specialist?	3/12	25.0%
Music Therapist?	3/12	25.0%
Geriatrician?	2/12	16.7%
Diabetes Educator?	1/12	8.3%
Note: About half the DONs reported that their RACF also had access to other diverse types of healthcare or health-related specialists. We are unable however to explain the low percentage of RACFs answering 'Yes' to the question about access to GPs. This is often a vexed issue for DONs and this may be a factor.		

The second interesting feature of the final batch of data supplied by the DONs is the number and types of trainees that had undertaken placements or made clinical education visits to the sampled facilities within the preceding 12 months (See Table 8 below). This is important information given the broad perspective – one that views clinical education for nurses in the context of ‘transitional education for neophyte professionals’ - adopted for this study. This data indicates the numbers of students and the range of disciplines already using these facilities as part of their practical training and thus provides an insight into the magnitude of the training load being borne by these facilities. This further raises the importance of questions as to how that load is organised and conducted and whether the present training sites are adequately structured and staffed for the work they are actually doing. Again, the most commonly-occurring disciplines among the visiting students appear towards the top of the table with the less commonly-occurring below. This throws into relief that there are some groups who might have been expected to appear among the visitors to aged care sites but did not.

Table 8: Students/trainees in the RACF during the past 12 months - How many and in what fields?

Students/trainees in these fields in the past 12 months?	Yes		How many students?	
	Count	%	Mean	Total
First Yr Nursing students/trainees	12/12	100.0%	23.4	280
Second Yr Nursing students/trainees	10/12	83.3%	14.4	173
EN students/trainees	9/12	75.0%	9.5	114
Certificate III and IV students/trainees	8/12	66.7%	7.8	94
Divers'1 Therapy students/trainees	7/12	58.3%	1.4	17
Third Year Nursing students/trainees	4/11	33.3%	1.00	12
Catering students/trainees	3/12	25%	0.8	10
Occup Therapy students/trainees	1/12	8.3%	0.17	?
Therapy assistant students/trainees	1/12	8.3%	0.08	?
Medical students/trainees	1/12	8.3%	0.0.	?
Honours Nursing students/trainees	0/12	0%	–	–
Music Therapy students	0/12	0%	–	–
Dietician students/trainees	0/12	0%	–	–
Speech Therapy students/trainees	0/12	0%	–	–
Geriatrician students/trainees	0/12	0%	–	–
Diabetes Educator students/trainees	0/12	0%	–	–
Podiatry students/trainees	0/12	0%	–	–
Hearing Specialist students/trainees	0/12	0%	–	–

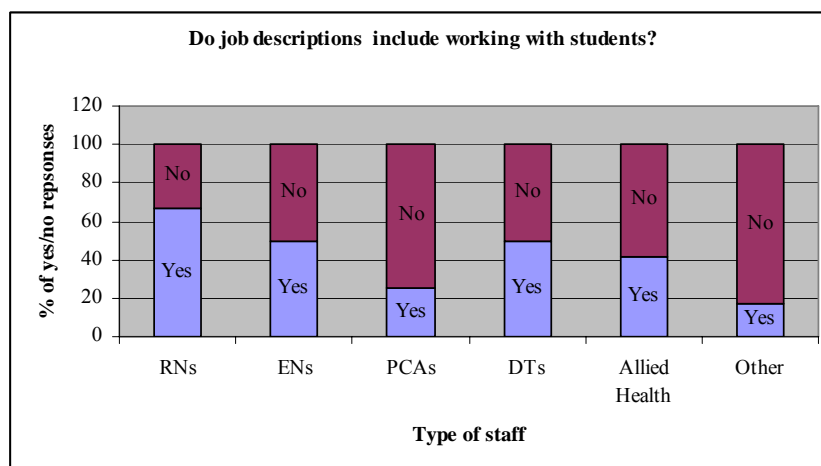
Continence Specialist students/trainees	0/12	0%	–	–
Psychogeriatric Specialist students/trainees	0/12	0%	–	–
Wound Specialist students/trainees	0/12	0%	–	–
Palliative Care Specialist students/trainees	0/12	0%	–	–
Pharmacy students/trainees	0/12	0%	–	–

(i) Not all respondents answered all questions and two 'Unsure' responses were recorded. The divisor in the 'Yes' column = the number of respondents who were able to answer either 'Yes' or 'No'.

(ii) One RACF – not necessarily the same one in each case - had hosted clinical visits/placements for Occupational Therapy students, Medical students, Catering students and Therapy Assistants; but the total numbers of these involved were apparently so low as not to 'survive' the rounding involved in the averaging process.

Third, and last of all in this section (Figure 3 below) is the result of asking the DONs whether or not the job descriptions of the various grades of staff under their control, explicitly include among the permitted/expected range of duties working with and providing direct or delegated supervision to students. When taken in the context of data presented earlier on the number of RNs likely to be on duty in one of these RACFs at any one time, it is interesting to see that approximately one-third of the RN respondents do not have a clause covering the provision of student training or supervision in their current job descriptions. It should be noted that the proportion of other staff roles with no explicit, formal responsibilities in this area is even higher, with half the ENs and three quarters of the PCAs not formally expected or required if directed to work with students.

Figure 3: Job descriptions that include working with students?

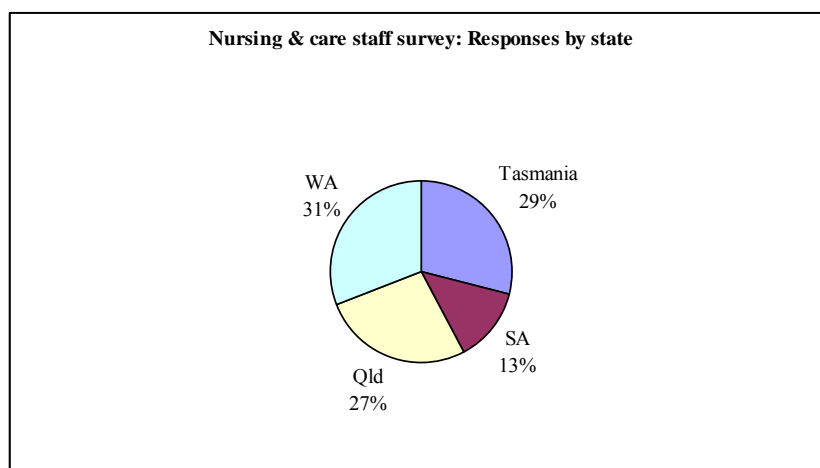


Note: the three occupational groups most likely to have sustained interaction with nursing students appear first.

Nursing staff survey

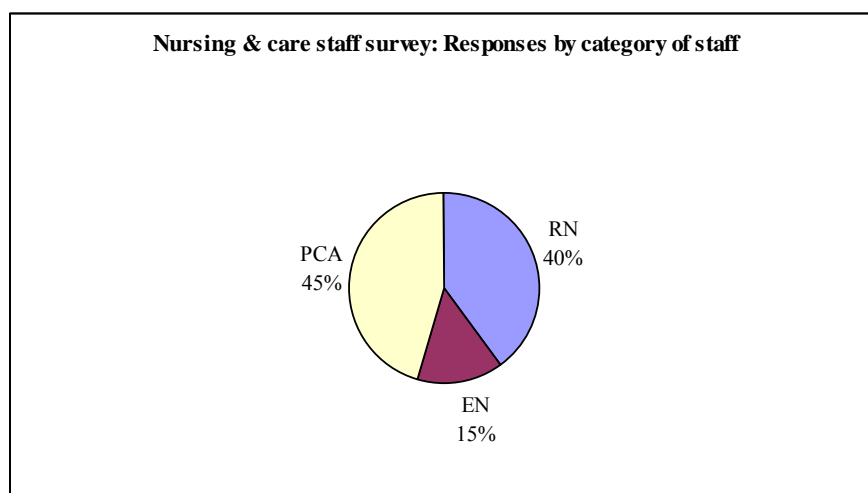
Having provided a profile of the main features and capacities of the RACFs included in the study sample of training institutions, we now turn to look more closely at the staff who work in them. The category of ‘nursing and care staff’, as it is used in this report, embraces three types of staff: RNs, ENs and PCAs or equivalent roles with different names. The data was collected from a group of 55 such staff. Added to it were the responses to the same questions from the DONs, all registered RNs. The state of origin of these participants is shown below in Figure 4.

Figure 4: Nursing and care staff survey: Responses by State.



The composition of the group of staff respondents is not representative of the staff profiles of any of the sampled institutions or of the residential aged care industry as a whole. The distribution of roles captured in this group of 55 staff members is as shown in the graphic below.

Figure 5: Distribution of participants



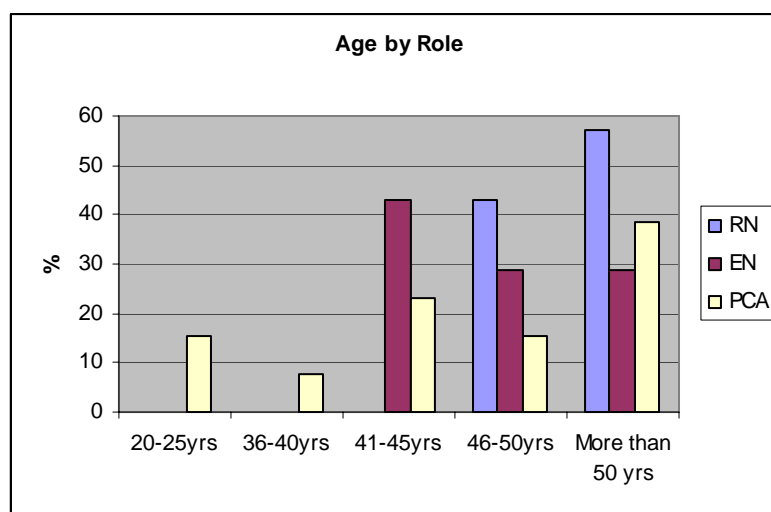
It is clear that, using either the staffing profile of the Australian residential aged care industry or of the ‘average’ RACF as constructed from our data, RNs are significantly over-represented among our respondents, ENs are under-represented and PCAs are even more under-represented (Richardson & Martin, 2004). When staff groups gather to express opinions or debate broader industry issues, an assembly of this shape commonly results. It should not surprise us; but it is not numerically representative of the structure of the industry’s workforce. Moreover it is likely that

the more ‘committed’ elements of the workforce will attend. ‘Commitment’ here does not simply describe an emotion or a professional stance, although it may include these.

With our eye on the training and acculturation experience of the visiting students, we need to remember that the group of respondents is significantly better educated and qualified than the industry workforce taken as a whole. We may need to bear this in mind when thinking about the lived experience of working in the industry day by day as the students will actually encounter it.

As Figure 6 below shows, 57% of nurses in aged care are 45 years or older. RNs in aged care tend to be older; with 40% being 45-54 years old, and 17% being 55-64 years old (57%) (Richardson and Martin, 2004). In 1999 the average nurse age in aged care was 45.2 years (Hogan, 2004) 3.6 years older than the national average for the whole nursing workforce regardless of nursing specialty. There is no reason to think the age gap would have shrunk.

Figure 6: Age of nursing and care staff respondents



The respondents also reported their total years of professional experience in nursing or care delivery and those data are presented in Figure 7 (below). All of the RNs had been in that role for more than ten years.

Figure 7: Your years of professional experience?

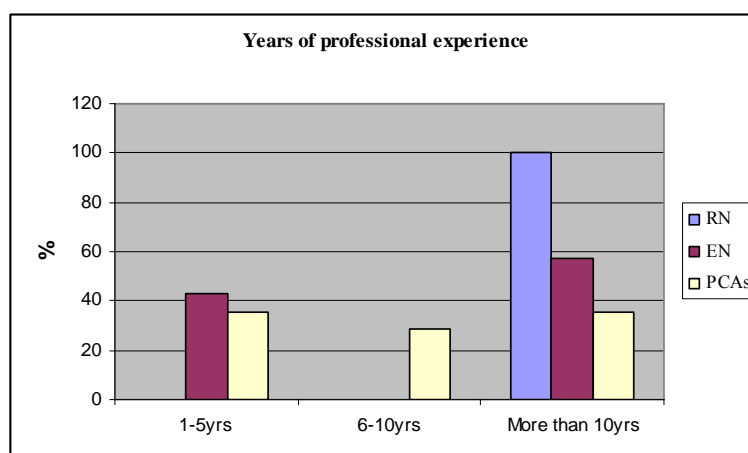
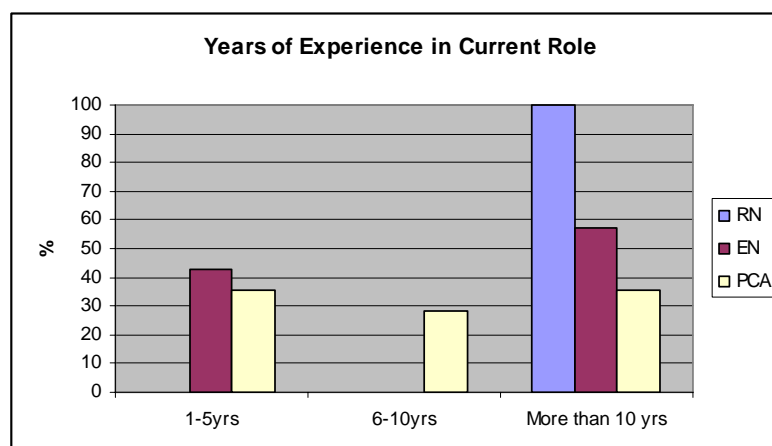
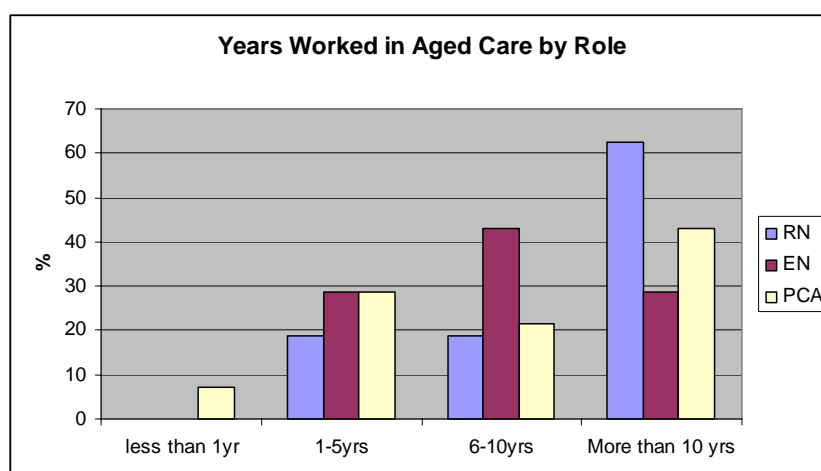


Figure 8: Years in Current Role



Three quarters of the total staff respondents had worked in aged care for upwards of six years and the great majority of those, about two-thirds of them, have more than ten years in the aged care sector (Figure 8 above) and more than 10 years in their current role (Figure 9 below).

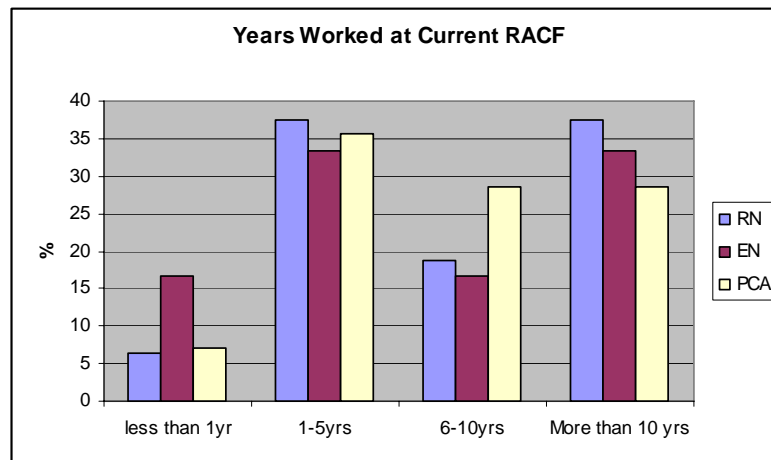
Figure 9: Years worked in aged care?



The data here gives us a picture of the length of the staff members' experience in the sector; and it does discriminate by staff group, revealing that RNs are more likely than other groups to have a long period of exposure to the residential aged care industry.

Another useful contribution to developing a perspective on such questions can be found in Figure 10 (below) which records answers from the nursing staff respondents to the question: how many years have you worked in this facility?

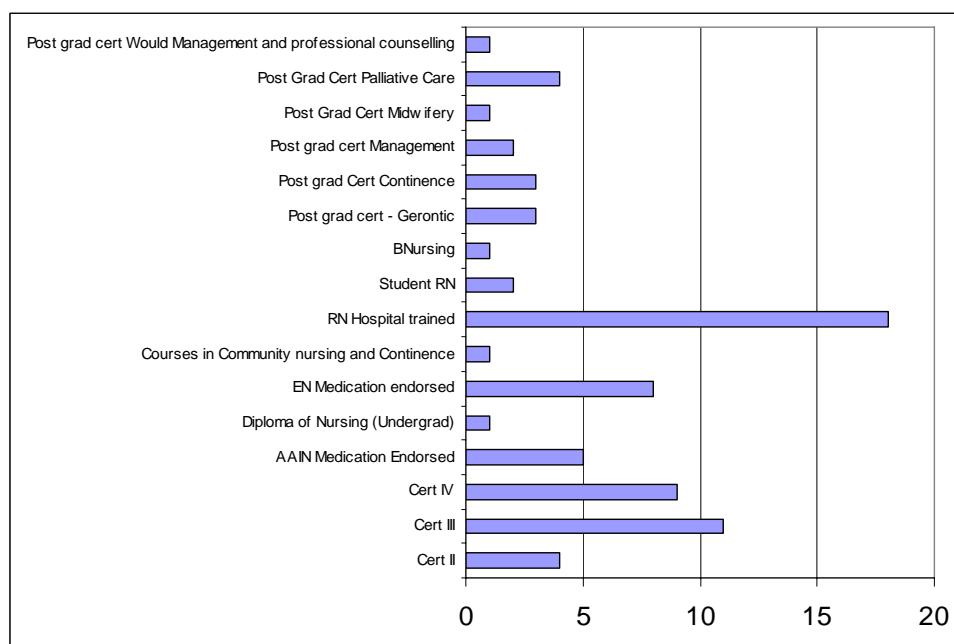
Figure 10: Years you have you worked in this RACF?



The above figure tells us that 25% of the nursing staff respondents have worked in their present facility for six or more years and a further 31% for 10 or more years.

The data in the paragraphs immediately above does not tell us anything about the quality of the experience or the use that has been made or is being made of it. Our data can provide no direct insights into that large and complex question, but it does allow us to form a broad picture of the previous education undertaken by the group.

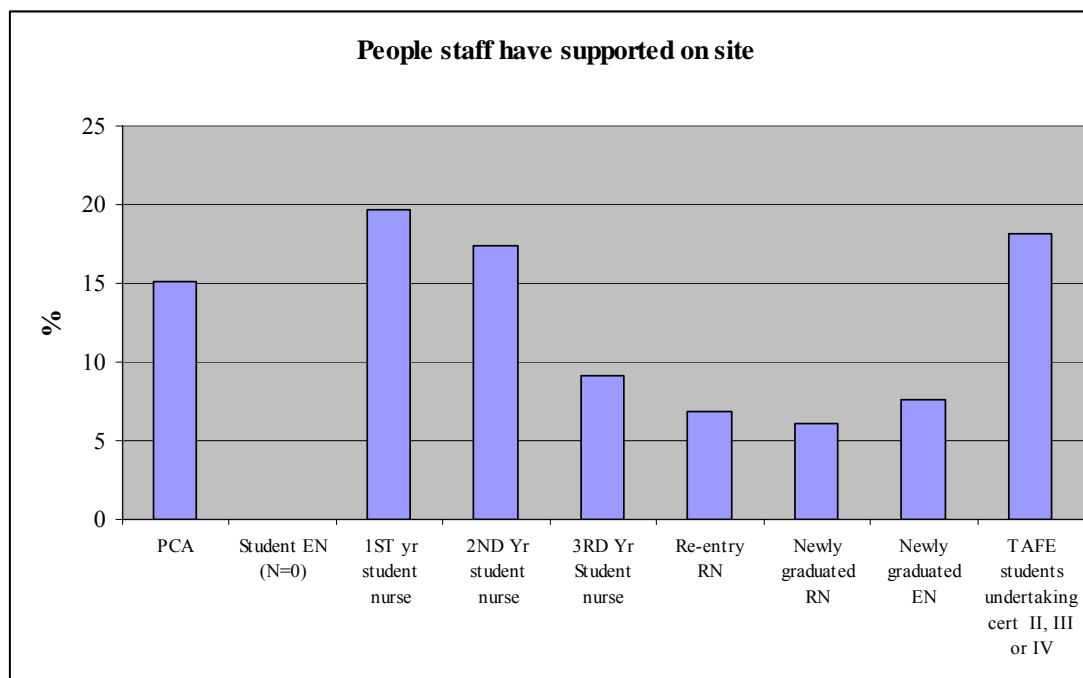
Figure 11: Qualifications of staff



The graphic above (Figure 11) shows a number of things of interest for this study, among them that the vast majority of the RNs are hospital trained and that relatively few have any postgraduate qualifications.

When the 55 respondents were asked whether they had ‘any prior training to act as a support person to students or other staff’, sixty percent of them answered in the negative.

Figure 12: Who staff have worked with as a support person



* The missing column (student enrolled nurse) reflects the data.

The above table (Table 12) provides a glimpse of the character of their actual practical experience as they described it. It shows the variety of people that staff report having supported in a training capacity.

Student survey

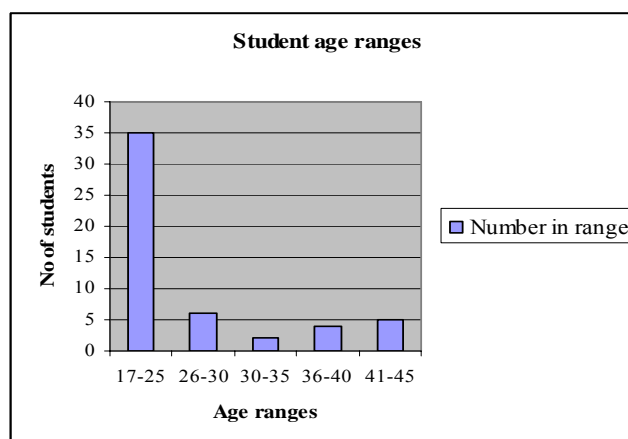
A total of 53 student surveys were received from the four participating states. Once again, these biographical and demographic data were collected to obtain a background picture of the participants and the experiences which might have influenced their views about aged care, especially residential aged care, prior to undertaking their clinical placements.

Table 9: Number of students surveyed by state

State	SA	Tas	WA	Qld	Total
Students	13	14	17	9	53

The most common age for students was in the 17-25 year range, with about 79 % of all students being 30 years and younger (see Figure 13 on following page).

Figure 13: Student Ages



Students were asked about their prior experience, if any, with aged care institutions.

Eleven of the 53 students (21%) had previously worked in an aged care facility, several of them in different roles at different times: two in a Therapy Assistant role, one as an EN and six as a PCA or equivalent. Others with prior experience had worked as housekeeping or catering staff. They were also asked about the duration of their work experience (see Table 10 below).

Nine of the eleven students who did have prior work experience reported the length of that experience. A majority (64%) of those who provided that information had worked between 1 – 5 years in the sector. One of the remaining two students had less than one year of experience while the final student had more than ten.

Table 10: How many years did you work in aged care?

Duration	Frequency
6 months - 1 year	9%
1 - 5 years	64%
More than 10 years	9%
Total	100%

Another source of prior knowledge and possible influences was visits they may have paid to RACFs to see relatives. Answers showed that more than half of all the students (54%) had visited a relative in a RACF.

The Orientation Experience Survey: Comparisons between student and staff reports

The focus, the questions and the data

Having established a profile of the institutions, the staff and the students, the research team now sought to gain a picture of the different groups' views of the orientation process as they had experienced it at the commencement of the placements. Orientation to facilities was identified in the Building Connections in Aged Care Project (Robinson et al., 2005) as having a critical impact on the clinical placement.

An orientation checklist survey was used to find out what information was conveyed to students by staff during orientation. Adapted from the Building Connections Project, the research team included in the Orientation Experience questionnaire 30 items which they saw as reflecting a reasonable minimum orientation aimed at making students arriving in an RACF feel 'at home', feel accepted, feel safe and feel ready to get on with learning through observation, questioning and direct involvement in providing care. In selecting items for inclusion they also drew on their own experiences in professional practice in aged care institutions and in teaching undergraduate nurses in Australian universities.

Each question offered the individual respondent the option of ticking 'Yes', 'No' or 'Unsure'. The checklist pro forma given to the staff was almost identical to the one given to the students: the student version contained two additional questions. Since those two questions cannot be the subject of the comparison that is our focus here, they will be dealt towards the end of this chapter.

A total of 120 respondents - 53 students and 67 staff members - completed the survey. Not all participants answered all the survey questions, but response rates were almost always high. However, one question ('Were you/students introduced to reception staff?') was answered by only 71 of the 120 participants. Another question ('Were you/students introduced to ENs?') received responses from only 109 of the 120 participants (92%), giving it the second-lowest response rate. These questions may well have been inapplicable to a number of smaller RACFs in which our respondents worked or had studied, or may have evoked some confusion among the students. The 28 remaining questions had response rates of 95% or higher. It is reasonable to conclude that the data fairly represent the expressed views of the four-state sample of 120 people.

It is important at this point to make two things quite explicit. First, the staff and students involved here were not reporting on precisely the same experience. They were each either employed or had undertaken a placement in a particular RACF. It may have been in Tasmania, Queensland, South Australia or Western Australia. It is true that small groups of the staff and the students worked or had studied in the same facility, but each of the facilities included in the study has its own peculiarities in the way it handles such matters as student orientation. This part of the Modelling Connections project is aiming to understand the nature of the orientation experience as a whole, as it is generally experienced, regardless of where in Australia it happens.

Second, it will soon become clear that the staff and student recollections and understandings of what information is conveyed during orientation usually conflict with one another, often quite sharply. So we must emphasise that the responses expressed the beliefs and recollections of the respondents. The researchers do not know 'what really happened during orientation', only what a considerable number of the parties to the process as it unfolded in a considerable number of facilities in four States believe happened; and those beliefs reveal patterned differences in opinion as between the groups, together with surprisingly high levels of uncertainty within each of them.

Results

When the two largely identical sets of questions about the orientation process were put to staff and students, 20 of the 30 questions drew answers that were different to a statistically significant degree. That is simply to say that the pattern of the distribution of ‘Yes’ and ‘No’ answers as between the groups is such as to have been unlikely to occur by chance. Those questions will be identified and discussed later in this chapter, but it can be said here that the researchers could find no possible explanation for the discrepant answers in any differences in the way the questions were framed, the respondents selected or the data gathered and analysed. In other words, the differences appear not to be an artefact of the research process. Rather, they appear to inhere in the conduct of the orientation process itself, more specifically the way the process is experienced and understood by the two different groupings of largely independent and differently located staff and students we surveyed.

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The first two questions on the survey sheet – ‘Is there a formal orientation program?’ and ‘Does one person coordinate student orientation?’ – were intended simply to confirm the existence of a deliberate effort to orient students, and they produced the following responses.

Table 11: Comparison of Student and staff perceptions of orientation

	Staff		Students	
Q1. Is there a formal orientation program?	Yes	88%	Yes	85%
	No	5%	No	11%
	Unsure	8%	Unsure	4%
Q2. Does one person coordinate student orientation?	Yes	83%	Yes	83%
	No	6%	No	13%
	Unsure	11%	Unsure	4%

For the remainder of this extensive intergroup comparison we have presented the 28 other questions, and the staff and student answers to them, in clusters of questions under five general topic headings. Each cluster, of between four and eight questions, is presented in one of the following graphic representations, Figures 14 – 18. Each Figure is headed by an indicative generic question representing the more detailed questions reported in the columns of the graph. These five generic questions deal with:

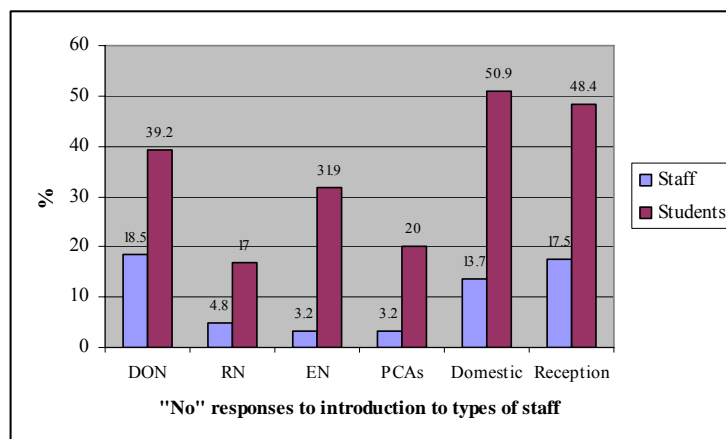
- student orientation to facility personnel
- student orientation to the facility’s site
- student orientation to emergency procedures
- student orientation to common RACF resources and tasks
- student orientation to job information

Student Orientation to Staff Members

Students and staff were asked whether, in their facility’s orientation process, students had been introduced to various kinds and grades of staff. Figure 14 (below) indicates that high percentages of staff are confident that this is done; but it also shows that students believe these introductions are

less common. Student ratings may differ by as much as 30%, particularly in relation to whether or not they were introduced to non-nursing staff members.

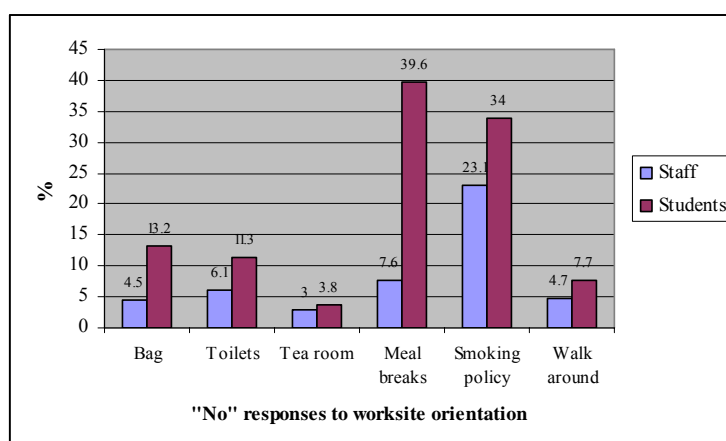
Figure 14: Percentages of staff and students who said 'No', to the question 'Are students, as part of their orientation, introduced to various (listed) staff members?'



Orientation to facilities

This cluster of questions aims to find out if students are adequately informed about how to find their way around the site. Are they given information such as where they may leave their personal belongings, where to find a toilet, the tea room, meal breaks, and smoking policy? Are they taken on a general familiarisation tour, a walk-around orientation? Staff consistently thought this had been better managed than students did. Differences weren't great, however, except in relation to information about meal breaks, where only 60% of students indicated this had been explained (see Figure 15 below).

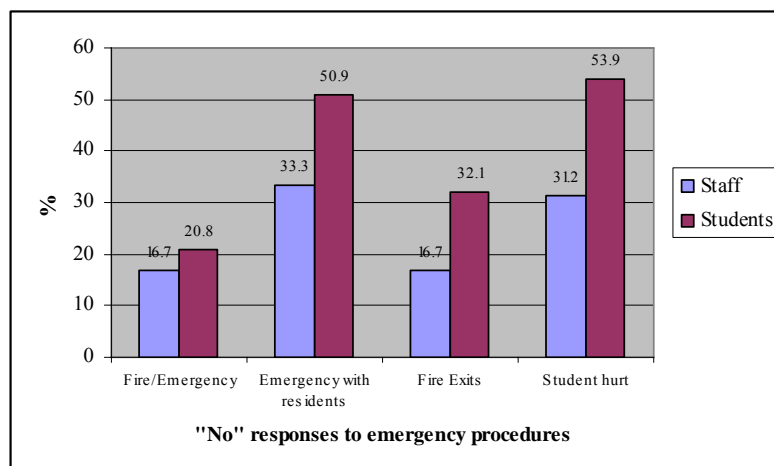
Figure 15: Percentages of staff and students who said 'No' to the question 'Was the facility's site shown and explained to students?'



Student Orientation – Emergency Procedures

Figure 16 (below) indicates the extent to which staff believe students are given information regarding emergency procedures. Notably, even the staff's highest ratings fall well short of 100% in all cases, a target which would be considered best practice. Student answers suggest a still bigger problem, with some very important areas seen by substantial numbers of students as not having been covered.

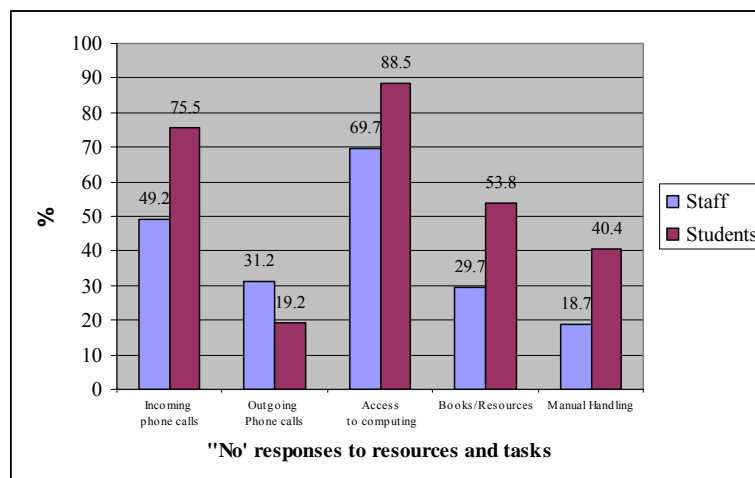
Figure 16: Percentage of staff and students who answered 'No' to the question on whether students were told about emergency procedures?



Student Orientation – Common resources and tasks

Figure 17 (following) indicates that once again staff rate the quality and thoroughness of the orientation given to the students considerably higher in most cases than do the recipients. Instruction on how to access books and resources might be expected to rate higher or receive more attention than the staff and student answers record when an important extended training function is in progress. However, it is notable that while only 18% of staff reported that manual handling was not routinely explained, students reported this rate to be over 40%. Given the central importance of safe manual handling in aged care this is clearly of concern. Furthermore, access to computing and use of phones for incoming and outgoing calls – and these are not trivial matters - is rated quite low by staff and even lower by students.

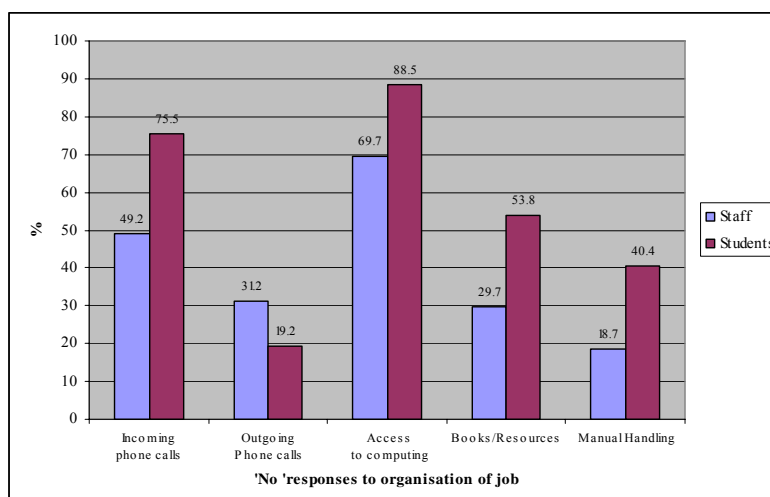
Figure 17: Percentages of staff and students who answered ‘No’ to the question ‘Are students informed about common resources and tasks?’



Student Orientation – Work information

Figure 18 (below) reports answers to a set of questions about generally mundane workplace routines of the sort that are easy to ignore until a problem arises but can then become very important and almost always require fairly quick *ad hoc* responses on which much can hinge. Staff felt orientation to such matters was being done with considerably more success and impact than students apparently believed was the case. Student ratings here were rather low, especially given the importance of the subject matter. For example, students did not feel that they were adequately informed about procedures such as the requirements for taking sick leave, going home early because of illness or other reasons, and what to do if they felt anxious.

Figure 18: Percentages of staff and students who said ‘No’ to the list of questions ‘Are students informed about how the job is organised?’



As was noted at the beginning of this chapter (page 28), the questions asked of the students included two that were not asked of the staff. The first sought the students' impressions of whether the staff among whom they were to work actually knew they were coming: 'Were the staff in the facility expecting you when you arrived?'

Slightly less than half the students, 48%, were convinced by their reception that their co-workers knew they were coming (see Table 12 below). We shall return to this point later when discussing the emotional side of the student experience of their placements.

Table 12: Students responses to whether staff were expecting them on arrival at RACF

	Students	
	Yes	48%
	No	31%
	Unsure	21%

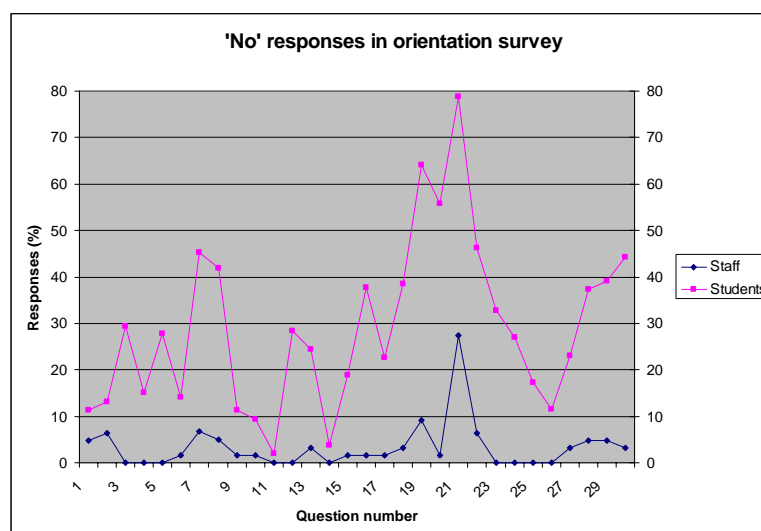
Significance of Differences Between Students and Staff Members

We now turn back to look again in a slightly different way at some of the information contained in the data sets just reviewed.

As noted at the beginning of this chapter and demonstrated throughout the preceding pages, the survey data clearly show that staff and student accounts of what information is conveyed during orientation do not match well. While the survey contained 30 identical individual items, the graphics so far have shown that in each of five main areas where orientation could have been expected and was intended, the students and, to a lesser degree, the staff themselves, believed either that the key topics had not been covered or were unsure as to whether the questions had been covered.

Where differences existed between responses for staff and students, as they did for every one of the 30 questions, a significance level of $p \leq 0.05$ was applied.

Figure 19: Questions 1-30 – Staff-Student comparisons



This graph refers to 'No' responses only.

The upper line on Figure 19 (above), represents the percentage of students answering 'No' to questions; while the lower line represents the percentage of 'No' answers given by staff. The salient point is the perceptual gap as to what has been covered in the orientation process. The 30 questions arrayed along the horizontal axis may be found on Table 13, page 34.

The questions 1 – 30 have been slightly abbreviated in some cases for inclusion in Table 13 (below). The columns record the percentage of the named groups that gave either ‘No’ or ‘Unsure’ as their response. Questions to which the two groups’ answers were consistently different enough to be statistically significant are shown in italics. The research team’s submission is that either ‘No’ or ‘Unsure’ answers are indicative of a defect of some sort in the orientation process.

Table 13: Orientation Survey Comparisons Between Students And Staff Members

QUESTIONS 1 – 30, ORIENTATION EXPERIENCE CHECKLIST	STAFF			STUDENTS		
	NO %	UNSUR E %	TOTA L %	NO %	UNSUR E %	TOTA L %
<i>ARE STUDENTS INTRODUCED TO THE DONS?</i>	0%	18.5%	18.5%	29.4%	9.8%	39.2%
<i>ARE STUDENTS INTRODUCED TO RNS?</i>	0%	4.8%	4.8%	15.1%	1.9%	17%
<i>ARE STUDENTS INTRODUCED TO ENS?</i>	0%	3.2%	3.2%	27.7%	4.3%	32%
<i>ARE STUDENTS INTRODUCED TO ECAS/AINS?</i>	1.6%	1.6%	3.2%	14%	6%	20%
<i>ARE STUDENTS INTRODUCED TO DOMESTIC AND CATERING?</i>	6.8%	16.9%	23.7%	45.3%	5.7%	51%
<i>ARE STUDENTS INTRODUCED TO RECEPTION STAFF?</i>	5%	12.5%	17.5%	41.9%	6.5%	48.4%
<i>ARE STUDENTS TOLD WHEN AND WHERE TO HAVE MEAL BREAKS?</i>	0%	7.6%	7.6%	28.3%	11.3%	39.6%
<i>ARE STUDENTS TOLD WHAT TO DO IN AN EMERGENCY WITH RESIDENTS?</i>	1.5%	31.8%	33.3%	37.7%	13.2%	50.9%
<i>ARE STUDENTS SHOWN THE FIRE EXITS?</i>	1.5%	15.2%	16.7%	22.6%	9.4%	32%
<i>ARE STUDENTS TOLD WHO TO CONTACT IF THEY HURT THEMSELVES?</i>	3.1%	28.1%	31.2%	38.5%	15.4%	53.9%
<i>ARE STUDENTS TOLD WHAT TO DO WHEN THE PHONE RINGS?</i>	9.2%	40%	49.2%	64.2%	11.3%	75.5%
<i>ARE STUDENTS TOLD WHERE TO ACCESS A TELEPHONE TO MAKE A CALL?</i>	1.6%	29.7%	31.3%	55.8%	13.5%	69.3%
<i>ARE STUDENTS TOLD WHERE TO ACCESS COMPUTING?</i>	27.3%	42.4%	69.7%	78.8%	9.6%	88.4%
<i>ARE STUDENTS TOLD</i>	6.3%	23.4%	29.7%	46.2%	7.7%	53.9%

WHERE BOOKS/RESOURCES ARE?						
ARE STUDENTS GIVEN OVERVIEW OF MANUAL HANDLING?	0%	18.8%	18.8%	32.7%	7.7%	40.4%
ORGANISATION OF SHIFTS?	0%	13.6%	13.6%	26.9%	13.5%	40.4%
KNOWLEDGE OF SHIFT FINISHING TIME?	0%	7.9%	7.9%	17.3%	1.9%	19.2%
TOLD WHAT TO DO IF FEELING SICK ?	4.8%	20.6%	25.4%	37.3%	23.5%	60.8%
KNOWLEDGE OF WHAT TO DO TO GO HOME EARLY?	4.7%	21.9%	26.6%	39.2%	21.6%	60.8%
KNOWLEDGE OF WHAT TO DO TO IF FEELING ANXIOUS?	3.1%	31.3%	34.4%	44.2%	21.2%	65.4%
IS THERE A FORMAL ORIENTATION PROGRAM?	4.7%	7.8%	12.5%	11.3%	3.8%	15.1 %
DOES ONE PERSON CO-ORDINATE STUDENT ORIENTATION?	6.3%	11.1%	17.4%	13.2%	3.8%	17%
ARE STUDENT SHOWN WHERE TO PUT THEIR BAG?	1.5%	3%	4.5%	11.3%	1.9%	13.2 %
ARE STUDENTS SHOWN WHERE THE TOILET IS?	1.5%	4.5%	6%	9.4%	1.9%	11.3 %
ARE STUDENTS SHOWN THE TEA ROOM?	0%	3%	3%	1.9%	1.9%	3.8%
ARE STUDENTS TOLD ABOUT THE SMOKING POLICY?	3.1%	20%	23.1%	24.5%	9.4%	34.9 %
ARE STUDENTS GIVEN A WALK ROUND ORIENTATION?	0%	4.7%	4.7%	3.8%	3.8%	7.6%
ARE STUDENTS TOLD WHAT TO DO IN AN EMERGENCY OR FIRE?	1.5%	15.2%	16.7%	18.9%	1.9%	20.8 %
KNOWLEDGE OF SHIFT STARTING TIME?	0%	3.1%	3.1%	11.5%	0%	11.5 %
WHAT TO DO IF LATE FOR WORK?	3.2%	22.2%	25.4%	23.1%	13.5%	36.6 %

Explanatory note : N was staff (RNs/Ens/PCAs/DONs) 67 and students 52.

The first feature of the data that is noteworthy from this perspective is that the skewing of the responses is consistent. Staff confidence in the transmission of the required knowledge is always higher than among the students. For the purposes of aiding investigation, it may be worth speculating on what circumstances could have given rise to these patterned disparities; but for the purpose of reporting it is quite sufficient to note that, on the evidence just reviewed, staff were a lot more satisfied that the orientation process was achieving its objectives than the students would have been.

No member of the research team has heard discussion in RACFs or among RACF staff of the kind of phenomenon detected by a comparison of the groups' responses. No published evidence of this phenomenon has been identified in the systematic review that preceeded this stage of the Modelling Connections study. Management and staff in the RACFs making up the study sample were unaware of the discrepancies, as were the clinical facilitators in the universities.

It seems to the research team reasonable to infer from the novelty of the report issuing from this part of this study that there must be some questions about the adequacy of the quality assurance and debriefing practices in use within the RACFs and within the universities. Why have they not been found before? Answers might be found in the absence or failure of quality assurance mechanisms applied to the orientation process; and in the absence or failure of feedback and debriefing practices both within the RACFs and the universities.

The levels of staff uncertainty and ignorance of the orientation process as carried out in their own workplaces must surely be seen as evidence pointing to a need to raise the profile of orientation activities among all staff. Positive change in this matter is likely to require strong leadership and, possibly, some help from the university sector.

As concerning as anything else emerging from the data is the risk that is being carried in areas such as managing what to do in the case of fire, the professional's legal and ethical duty of providing effective and timely care and legal liability in the areas of occupational health and safety. The matter would appear to be a serious one for the service providers. It is only too easy to imagine the circumstances in which some of the information uncovered here might be elicited in a legal context. But our focus in this project is on the adequacy of the RACFs as teaching institutions; and one is compelled to ask what the experience recorded here is teaching the young student nurses about the importance of safety and risk management in the healthcare workplace.

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One final insight into the adequacy of the present system of training can be gleaned from the answers to the second of the questions that were mentioned at the beginning of this chapter as having been addressed to the students but not to the nursing staff. The second of the two questions – 'Was the RN role in a RACF what you expected?' (See Table 14 below).

Table 14: Student perceptions of RNs role

'Was the RN role in a RACF what you expected?'	Yes	53%
	No	32%
	Unsure	13%

While it is a 'yes/no' option, the reasons for the answers given may be complex and may be contradictory, making it difficult, to infer much of a substantive nature from this result. However, on the other hand, it may be easier to agree on the importance of the fact that almost half of the students found what they saw and understood of the RN's role in an RACF to be other than they expected.

Chapter 2: Quantitative data – setting the context

A fuller discussion of issues arising from the data presented in the foregoing section of the report can be found at pages 73 to 77 in this report; and conclusions/recommendations flowing from those discussions can be found at pages 1 to 5.

3. Qualitative data: exploring the issues

In the latter half of 2005 and early 2006, in each state nominal and focus group discussions were held with separate groups of DONs of numerous RACFs (including some not partnering the Universities for this project)¹, staff who worked with students during their clinical placements in the participating facilities,² and students who had participated in these clinical placements³ (N= 53 students, 53 preceptors and 21 DONs).

The arrangement adopted allowed for the first part of the gathering to be conducted as a focus group and the second, longer part of the gathering to be conducted using the nominal group technique. Group discussion in both segments was facilitated by two project staff.

Group size ranged between 1 and 9 (range 3-8 for Tas, 3-9 for WA, 4-7 for QLD, 1-7 for SA). In most instances, student focus groups were held in the clinical placement settings, in a private place within the facility. This was also the case for the staff focus groups.

Student nominal/focus groups were held at the end of their placement in a RACF. In general, focus/nominal group discussions conducted with mentor/preceptors were held between 4 and 8 weeks after the students had completed their last clinical placements in the RACFs, with DON groups falling within these limits.

The conditions under which the focus groups were held, the way the data was processed and analysed and the resulting findings will be set out before we proceed, later in this chapter, to review the conduct and results of the nominal groups.

Focus Group Data

The meetings with the respective participants began with a 15 minute focus group discussion. The intent was to provide in-depth qualitative data. Focus group discussion was facilitated by two project staff and audio-tape recorded with the written, informed consent of participants.

Two or three open ended questions as shown in Table 15 (following), were used to guide the discussions. These were derived from discussion between the Chief Investigators with particular reference to their prior experience with the Building Connections in Aged Care project (Robinson, et al., 2005) and the 'Clinical Placements in Residential Aged Care Facilities and their impact on nursing students' attitudes and career plans - a pilot study' (Abbey et al., 2005) and focused on impressions of student placements and mentoring in the facility.

Focus Group Data Analysis

All of the qualitative data from the open ended questions used in the focus groups were transcribed and sent to WA for analysis. Here, transcript data were entered into the QSR International's NUD*IST software program (Version 6), which was used to assist in the categorising, and sorting of text. The two investigators from WA and the Project Manager from this State were involved in the analysis process and agreement among the team was required before findings were as accepted final. The Project Manager and one of the investigators had already been involved in collecting the WA data.

¹ 2 In Tasmania, 2 in Western Australia, 1 in Queensland and 1 in South Australia

² 2 in Tasmania, 2 in Western Australia, 2 in Queensland and 2 in South Australia

³ 2 in Tasmania, 3 in Western Australia, 2 in Queensland and 2 in South Australia

Table 15: Questions for the Focus Groups

STUDENT NURSES:
1. COULD YOU GIVE US YOUR IMPRESSIONS OF THE PLACEMENT OVERALL? 2. COULD YOU GIVE US YOUR IMPRESSIONS OF THE EFFECT OF MENTORSHIP? 3. COULD YOU GIVE US YOUR IMPRESSIONS OF YOUR REACTION TO RESIDENTS?
STAFF (ENS, RNS, AND PCAS) WHO WORK AS MENTORS/PRECEPTORS TO NURSING STUDENTS:
1. COULD YOU GIVE US YOUR IMPRESSIONS OF STUDENTS' PLACEMENTS OVERALL? 2. COULD YOU GIVE USE YOUR IMPRESSIONS OF YOUR EXPERIENCES MENTORING STUDENTS?
DIRECTORS OF NURSING OF AGED CARE FACILITIES:
1. COULD YOU GIVE US YOUR IMPRESSIONS OF STUDENTS' PLACEMENTS OVERALL? 2. COULD YOU GIVE US YOUR IMPRESSIONS OF YOUR EXPERIENCES HAVING STUDENTS ON PLACEMENT IN YOUR FACILITY? 3. IF YOU HAVE OTHER STUDENTS, FOR EXAMPLE PHYSIOTHERAPY OR OCCUPATIONAL THERAPY STUDENTS, IN WHAT WAY DOES YOUR FACILITY HAVE DIFFERENT PROGRAMS TO ACCOMMODATE THIS?

The data were coded, clusters of data formed categories, and themes were developed from these categories, as prescribed by Savage (2000). An accurate representation of participants' experiences and perceptions of the clinical placements was the main goal of this part of the study (Streubert, 1995). Rigour was demonstrated by using the criteria established for qualitative research: credibility, transferability, dependability, and confirmability (Guba & Lincoln, 1989). The descriptions of our focus group participants and of the clinical placement situations, allow the transferability of findings to be assessed. Use of three different data sources, DONs, staff and students enhances the dependability of findings.

Focus Group Data Findings

We present the findings of the qualitative analysis of interview data under headings that mirror the steps in the clinical placement process. This is because the emergent themes were all clearly derived from the stages of this process. The starting point for the process was marked by the students' attitudes towards and perceptions of aged care as they were at the time of the commencement of the placement. 'Preparations' related to student preparation and the preparations made by the university in conjunction with the aged care facilities. To an extent, these preparations built upon the perceptions of the students' attitudes and perceptions that were held by the university and facility staff; undoubtedly, they tended to shape the students' experiences. These experiences, in turn, had outcomes for the students themselves, the facility staff, and the residents. In the longer term, the clinical placement outcomes have the potential to become either barriers to or opportunities for developing a professional identity for aged care nursing; they can enhance aged care nursing as a profession or denigrate it.

Student attitudes and perceptions at the start of the placement

Theme 1: First of all, it was scary

Whereas some students already had experience in working in residential aged care, generally as care assistants, others came to the placement having had little or no prior contact with exceedingly frail, older people. Students' attitudes on arrival at the facility, according to staff observations, were similarly diverse, ranging from enthusiasm for the placement experience to extreme reticence about getting involved at all. Sometimes, facility staff reported that students felt that resident care was somehow 'beneath them', which provoked a somewhat hostile response from staff. For example, a staff member stated:

'I've had them say to me 'no I won't – that's dirty work' – I was horrified. I said 'well what do you think nursing is?'. I said 'do you think you are going to get a job when you graduate – and you're not going to clean up...?'

In a similar vein, another staff member said, *'I've had a couple of students looking down upon me as 'you're down there and I'm up here and that's where you will stay' and 'that's awful.'*

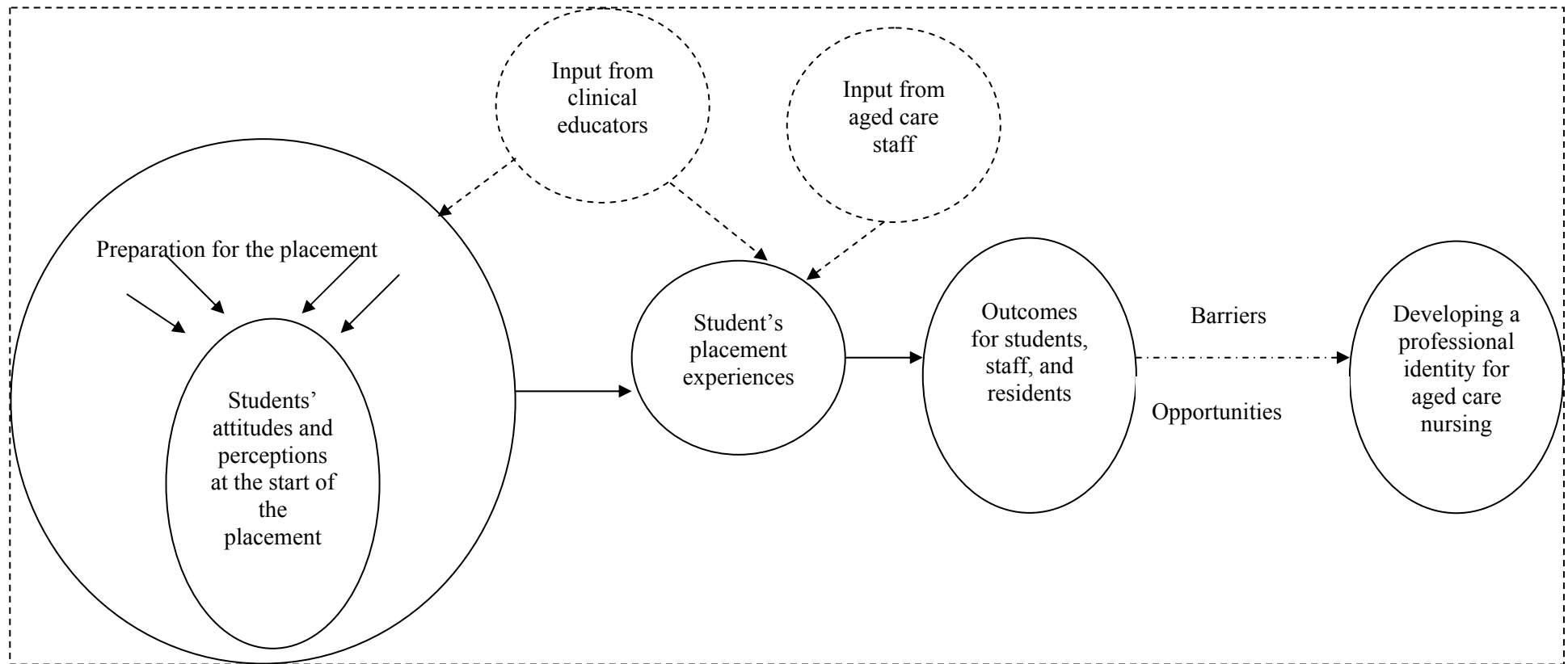
The students themselves reported prior expectations of the placement that were primarily negative. For example, some students came to the experience believing it to be a waste of time that could have been better spent in acute care. Others held the view that aged care settings would be a depressing environment. Two such examples of what students expected were *'people dying and old, sick people'* and *'a bunch of people waiting to die'*. In contrast, some students anticipated enjoyable social aspects when interacting with residents, one saying *'[I] just thought that we would spend more time with the residents, like listening to their, like stories, life stories, you know. Building rapport, things like that'* and another stating *'My expectation was ... that I would be able to speak and have a conversation...'*

Another view expressed by students was that this was one more step to be taken towards becoming a nurse - providing care for another human being, and putting into practice other things learned in the classroom. One stated

'[It's about] getting in close and personal and not being intimidating and vice versa being intimidated' and another said '...[to] probably to do more nurse things. In terms of taking obs, documentation, being exposed to ... not so much to do but be exposed to experience, um medications, treatments...'

It became clear during the discussions however, that the overwhelming emotion experienced by students when facing the reality of the placement was fear or apprehension. Those students who had worked as carers were sometimes apprehensive about going into such a setting in a different role, others who had had less contact with frail older people were much more fearful, students' comments including: *'First of all, it was scary, heaps out of your comfort zone...'*, *'at first I was scared'*, and *'I was a bit afraid of them (the residents) to start with'*. This fear and apprehension was also noted by facility staff members, one saying, *'I think they are terrified most of them, frightened out of their wits and really unsure'*.

Figure 20: Conceptualisation of student nurse clinical placements



Theme Two: Preparation – Room for improvement; Theme Three: It starts with destroying the illusions

The underlying theme whenever staff, students and DONs were speaking about preparations for the clinical placements was that there was *room for improvement*. There was another common but related theme - that students' false beliefs about the placement had to be dispelled. It was acknowledged that students came into the setting with a variety of, mostly erroneous, expectations and attitudes. This situation meant that considerable preparation needed to occur during the first day or two of the placement, which involved a prompt orientation to the reality of the situation. That this preparation should have occurred prior to the students' arrival was implicit in much of the data, for example when students indicated that staff didn't even seem to know that they were coming.

Only a few students criticized their preparation overtly, but many comments made it obvious that they would have benefited from additional preparedness. One main issue for them was that they needed to invade the personal space of residents who couldn't communicate and, therefore, couldn't respond when asked if this was acceptable to them. One student stated:

'I've never done anything remotely close to this. So when we got round to bathing, showering the residents and everything, that was, okay it was a bit of a, it was a major shock to my system because I've never done this before. It's going into other people's personal space. ... I felt like very like, very intrusive in, in a way, it's very like, yes, you want to pull back immediately and that's, that's where I struggled, I struggled, I found I struggled with that.'

Another student explained that the university preparations just didn't match the reality of the placement: *'We were sort of feeding each other and lifting each other at Uni ... but here they are a dead weight and at Uni you would be like 'Can you roll over for me?' and they do.'*

Some students also struggled with the reality of death being a likely phenomenon in this setting; it seemed that they were articulating this reality, as shown in the illustrative excerpts reproduced in the previous section, but not truly understanding it until the placement began. One student said: *'It hits you, the fact that everyone will get to that stage, even yourself... it reminds you of your inner sense of your own mortality ... it just hits you ... it makes you want to pull away.'* Other students' comments included *'I didn't realize how bad someone with dementia [could get] ... you hear about it but seeing it, it's totally different'* and *'There's no amount of preparation that you can do in the classroom to give you an indication of what it's like. ...it's very difficult when you're confronted with all these new and strange and scary things.'*

Two more positive comments, however, related to students' preparation concerning residents with dementia, and how that helped them:

'we did a mental health placement before this ... it made the dementia guys a lot easier to handle'

and

... sometimes they would bring a story from yesterday and think like I was working with them yesterday and I knew how to cope with that ... I remembered what I had learned before and, yeah, it was good.

Students often reported feeling unsure of what they should be doing in the clinical setting and facility staff members recognized that they were struggling, one suggesting an orientation day before students joined in with the work, another indicating that a placement with residents receiving low level care would have been more advantageous because these

residents were better able to communicate. Many staff specifically commented on the confronting nature of the work, one saying of the students, '[they've never] *perhaps seen an actual naked older person. So that comes as a hell of a shock and they can't cope with that, and to me they should have some preparation for that...*'; another saying '*...it was shock horror that they would have to wipe someone's genital regions, they had no idea*'. A further, similar statement from a staff member was:

Aged care is so different to any other nursing. To a lot of people it could be a shock to actually see how older people can be. If they get this concept of older people being nice, sweet, don't go to the toilet, don't wet themselves ... and they come into here and see that they do all these things, it is a bit of a shock.

A need for additional preparation for facility staff was also recognized by these staff. Staff reported feeling that they didn't have the knowledge to offer guidance in this area, one stating,

'a bit more preparation would help the experience because obviously it's very stressful- staff don't usually have a choice with these students and you're not sure what they can do, what they can't do – the boundaries'.

Another said:

... there could be a bit more communication....From the coordinator, because we don't know if the students are coming to our house on a particular day. We don't know which showers to leave Sometimes we're told they're coming and they don't come.

One group of facility staff members was also confronted by the fact that more preparation was needed for students to cope with the death of a resident:

... one of the residents passed on . We were just thinking well that's done ..., she's passed on, but this poor students was thinking 'Oh my God, somebody has died', so that then was 'Oh, we should look at this issue ... this was the first experience with that student so that was something we had to rethink ...

A DON made a similar comment, saying that mature students had life experience that prepared them better for aged care but that the younger students were sometimes overwhelmed: '*one [in the] last group who came through was in tears from being subjected face on with this end of life stage, not a pretty situation and death – first time experienced – can be pretty overwhelming.*'

The DONs also commented that communication between the University and the facility was the key to successful student placements but that there could be serious ramifications if this communication failed, for example, the purpose of the placement could be entirely lost: '*...quite often arrangements for student placements are made at a higher level and the when the students arrive they're just seen as a bit of cheap labour.*' The need for good communication was echoed by students, some saying that staff didn't even seem to know that they were expected in the clinical setting, one student said, '*... it's just like they didn't even know we were coming.*' Other issues the DONs indicated had arisen in the past were that different students to those expected had turned up and placements had been cancelled without the facility having been notified. The DONs also stressed that the students should be aware that the placement was a situation where appropriate workplace behaviours were expected, one saying, '*the School of Nursing may like to go through the basics, this is what you do in the workplace ... because a number of them ... don't know about ringing up sick or turning up.*' Another DON reflected upon a situation that had obviously caused problems, saying '*... it comes the last day of placement and they've got all the forms to sign and they're hanging outside the office because their preceptor happens to be on an RDO.*'

Theme Four: Input from the facility staff – Facing competing needs

Much of the students' time was spent with formal carers rather than with RNs or even ENs. Some of the students were unhappy with this situation and one reported that they had protested about this, stating '*... you're walking around with ... [carers] a lot until we sort of spoke up and said you know basically we know how to do this stuff, we want to know and learn the other things, the important stuff...*'

Numbers of comments from staff indicated that working with the students was difficult for them, involving a lot of extra work when their workload was already intense. There was an implicit theme identified as '*facing competing needs*'; the existing workload of facility staff related to the needs of the residents, but the students' needs were also substantial.

Staff comments about the difficult situation in which they were placed included:

[It's] a lot of hard work – you've got to concentrate on what you're doing and make sure you're telling them everything they should know.

... you just have so much of a workload ... it's very overwhelming and you feel you're short changing, you know, your student, you feel like you should be giving them more time and more information but the time just doesn't allow for that.

... we get really cheesed off ... we don't get any extra money, we don't get any training except the practical skills that we've all got

... we have a lot of Chinese students here who don't understand English and I find that exhausting – you're repeating the same thing over- you've got all these other demands on you ... and you've got them like little sheep following behind you...

My working shift with students is a long drawn out, hard session ... I love working with the students, don't get me wrong, but it is a lot more hard draining work on the actual carer because you are thinking for them and yourself and you have to be so watchful of what they do because you could end up with massive injuries...

... it all comes naturally when we do what we do but when you actually have to stop and think that you've got to explain every little step as you go and why...

At least one of the staff 'buddies' apparently decided that working with a student was just too difficult, the student saying:

... the first day of washing people... the guy who I was working with walked off and left me, came back and then said I wasn't going quick enough. And I just thought. 'Well, wow, that's my confidence just gone! ... Wow, it was so hard.

For formal carers, as opposed to RNs and ENs, the situation could be particularly difficult. There was an undercurrent of feeling from the staff that the students valued spending time with carers less than spending time with other staff. One staff comment stated, '*I think some of them need to realize that you can learn just as much from a carer as you can from an RN as in just seeing the resident as a whole person.*' Another carer, however, felt that the students didn't have an opportunity to relate theory to practice when working with a carer, and at least one student's perspective was that it was the RNs and ENs who provided the much needed theoretical perspective of care, this student said:

... it was to our advantage that we had the EN because she sort of ... could explain like the rationales .. sort of like theory into practice.

Nonetheless, students' comments about the staff were often strongly appreciative of their efforts and included:

The staff seem heaps friendly and happy to help you.

... as you went on , the staff were good...

They were quite nice ... they showed me a lot – they gave me lots of tips and techniques and they were wonderful – weren't rude or anything like that.

... we didn't even have to ask her to watch us give out drugs, she'd just come straight away to supervise ... she was well informed and that made such a difference.

However, sometimes students felt that staff members were intimidated by their being there. One student said of an RN, *'I felt she wasn't accepting of having me there or me asking her questions and perhaps she felt a little bit threatened by some of the questions I was asking her'*.

Another student was disappointed by the effect of the busyness of the carers on their relationships with residents, saying that there was no time for a personal connection between the resident and the staff member. Student needs for staff care and nurturing were acknowledged by staff and students. *'An arm around the shoulders ... makes a big difference'* was a staff member comment, and a student said:

One of the nurses I've been with , for probably about a third of my shifts, was kind of like my mum ... she looks after me, it's really good like she's a good preceptor I think, someone who takes care of me.

One student who was 'buddied' with an agency staff member found this difficult because she could see the change in the care for the residents when they weren't known as individuals, '*...*

... there wasn't that sort of connection there, like she didn't know any of them by first names ... and just didn't have any background to be able to talk to them properly.

Theme Five: Student experiences – *It was just like – 'whoa'*

One student epitomized the sense of being overwhelmed with the confronting nature of the aged care clinical placement that was common to the students who had had no prior experience in an aged care setting by saying – *'It was just like – 'Whoa''*. As previously indicated, the issues of invading the personal space of such frail older people and trying to see if it was, in fact, possible to communicate with them, were difficult for these students to deal with, but they did express pleasure at the gradual acquisition of relevant skills in this area. Some of the students with previous carer experience, however, felt that they were just treated as an extra staff member with no educational needs.

As they worked through their unfamiliarity with the clinical setting and began to grow in confidence, there were both rewards and setbacks for students. One setback was when students were unhappy about the care that they saw being provided. They developed a level of knowledge and understanding that allowed them to discern a situation in which a resident's vulnerability was highlighted, but appeared not to feel confident enough to question clinical practice within the setting. One student said:

All four of us were in one room and this little old lady, she's got her arms up here because she doesn't want people to see her and she's going 'Oh, Oh, Oh', and no one would get out ... there was just everyone in there trying to dress her and I felt very sorry for her.

Another student said *'I got a bit emotional when I went home – a resident was left on the toilet for nearly an hour... she said to me, 'oh this is awful' ... that really got to me.'* One more explained that it was the institutionalization that she found confronting, saying *'... all there is, is 'right you sit here, in another hour's time we'll take you to the toilet, in two hour's time then you're going to do this...'* Students also sometimes reported a lack of guidance even

in areas that could have been easily rectified, such as providing information about a resident for whom the student was expected to assist in care provision.

Some students, however, expressed gratitude to staff who ‘looked after’ them at this difficult time, or ‘mothered’ them. Others felt in the way, one student saying,

... they just basically said, ‘OK, you can come and watch.. So we observed, which was good but we would have liked a hands on and they said, ‘Oh, you can just make the beds if you like.’ So we just ended up making beds and just their comments throughout the day ... it was just like we were in their way.... So it was a bit of a bummer.

Students also resented it if they were criticized for seeking out what they perceived to be valuable educational experience. One student felt that, when they needed to seek out learning experiences, they could not always do this in an open way, saying:

...it’s terrible when, you know, these learning experiences aren’t being created for you and you feel like you have to actively pursue them but you have to do it in such a diplomatic way ... it’s a shame we have to waste so much time doing that stuff.

Some students were also surprised at the role of the RN within the facility, RNs providing little ‘hands on’ care – one student saying ‘they don’t get their hands dirty.’

The rewards for the students occurred when they found that they were remembered and/or appreciated by the residents and came to know the residents’ capabilities and personalities. One student said, ‘... if I’d dealt with them before it was really good,’ another said, ‘In the first few days they don’t know who you are but in the second week they start to smile at you – some of them recognize you – I feel really happy about that,’ and a third said, ‘I think that’s the best thing about the practical experience... the relationship between the residents and myself. That’s what I’ve enjoyed the most.’ A fourth student said that the one resident she met who laughed and chatted with her, made her placement a joyful experience, saying ‘... she was so appreciative that we were there and she made, just made me feel that, maybe the other residents, they can’t verbalise that, but they might feel some of that gratitude too.’

Outcomes for students, staff, the facility, and the residents Theme Six: I finally realised

Despite the recounting of many negative experiences, a common theme for students was that they did develop communication skills and improved confidence during the clinical placement and, for many, this was a deeply satisfying and positive experience. At the very least, it was viewed as ‘a [very rushed] taste of what it’s like’. Another student said ‘I loved it. My expectations of it changed a lot, I thought it would be a bit more of a depressing environment but ... I loved it’. Yet one more said, ‘... it turned out really well – residents were happy and it really impacted’. The positive outcomes were supported by the views of the staff, who indicated that students’ attitudes towards aged care seemed to improve during the placement, and by those of the clinical educators, one saying

‘... the communication skills while they have been here, most have improved dramatically ... they have gained a lot of confidence’.

One student described a particular moment when she made a connection with a resident, saying

‘I was feeding a patient ... he didn’t want any more food... he just moved his hand up really slowly to his face ... like moving his hand in front of his nose and I finally realized that he wanted his nose to be blown ... and I found that, that like hit me so hard ... they can still kind of communicate to you even though they can’t speak to you’.

The words '*I finally realized*' epitomised the way in which these students grew in their skills and understanding. Another expressed satisfaction with newfound skills saying '*I know this – I can do this*'. An additional view, however, expressed by one student, was that the learning experience was not nearly sufficient '*...to be very honest with you ... I didn't learn enough ...it was a real pity because it feels like a waste of time*'. In particular, a short placement period was perceived as being of less value than a longer one would have been, another student saying, '*... you still want to give them their dignity and all that sort of stuff but ... we didn't have time to build up a rapport with them and, you know, it was a bit hard that way, for sure*'.

Residents were generally perceived as enjoying the students' input. A student stated:

...they're like, 'oh, are you leaving us tomorrow? That's really sad, will you come back and visit us?' ...Students have more time to sit with them and talk to them... it's so nice to talk to them. It's really good.

However, an alternative perspective of the residents' experience of the placement was that they had to contend with new and less competent staff,

Sometimes they're a bit shy or a bit nervous or a bit whatever ... that's something the resident has to deal with too ... and it's also in their place (their home) being showered by somebody that they don't know ... the hands on is something the residents have to be prepared for.

Staff within the facility acknowledged their limitations and reported feeling challenged by the placement experience but this challenge also brought rewards for them and the facility because they were kept 'on their toes' and were sometime stimulated to update their own knowledge to become more confident when mentoring students. Staff also took great pleasure in seeing the students gain in confidence and skills. Those who received certificates from the universities valued these as recognizing their contribution. In more global terms, their contribution to the placement was seen as an investment in the future of aged care.

Developing a professional identity for aged care nursing

The clinical placement experience was often regarded by staff as a wonderful opportunity for them to demonstrate their commitment to aged care nursing. Moreover, staff also saw the placement as a wonderful opportunity for students, one staff member saying '*The actual caring for the patient is exemplified in aged care.*' This statement, however, serves as a final reminder that student involvement in basic care in the placement setting was mainly guided, not by an RN, but by a carer.

Nominal group data

As noted earlier, the nominal group discussions in each state were conducted with each group as part of a two-stage meeting, following directly from the end of the focus group stage. Those participating in the focus groups remained to take part in the longer nominal group discussions.

The nominal group technique was initially developed by Delbecq and Van de Ven (1971, 1975). Originally used to facilitate group decision making, it has also been used in areas such as curriculum development and course evaluation (Chapple & Murphy, 1996; Lloyd-Jones et al., 1999). It involves a structured approach to small group discussion useful for obtaining, prioritising and analysing responses to a set of questions relatively quickly and consistently. This was particularly important in the current multi-state project.

Nominal group questions (Appendix 7), like the focus group questions, were also derived from discussion between the Chief Investigators, with particular reference to their prior experience with the Building Connections in Aged Care project (Robinson et al., 2005) and the QUT study (Abbey et al., 2006). Questions for:

Students included their feelings on the first and last day of placement, barriers to settling in, the activities they were engaged in and with whom, and their experiences with residents.

Preceptors included how they facilitated students' 'settling in' to the placement, the amount of time students spent with various staff (e.g. RNs, ENs), supervision strategies, and benefits and barriers to having students in the facility.

DONs included student needs, costs involved with the placements, strategies to prepare staff, and how placements are arranged.

A facilitator and notetaker were present at each group. Participants were asked the first question from the nominal group interview guide. They were instructed to privately write down up to five short answer responses. The facilitator then requested one response from each participant to be read aloud to the group, with the notetaker writing them down on butchers paper (or equivalent); this continued until all responses to this question had been delivered and scribed. Participants were then asked to nominate the five (or fewer) responses that they considered most relevant and important by placing a sticker next to the written responses (n.b. each participant could place no more than one sticker next to a particular response). The preceptor nominal groups allowed differentiation of responses from RNs, ENs and PCAs by assigning different coloured stickers to each staff category. This process was repeated for the remaining questions.

Nominal Group Data Analysis

Raw nominal group data for each group were tabulated with responses listed in rank order. The percentage of participants who had voted for each response was calculated. A meeting was held between the chief investigators and two project staff members to examine the raw data and identify themes common across states (thematic analysis).

Nominal Group Responses

The nominal group responses are presented in two tables; the first table (Table 16 below) presents the data and questions asked of students and mentor/preceptors, compared horizontally where appropriate. The second table (Table 17 following) presents the questions and data obtained from the DON groups.

Table 16: Student / Mentor/Preceptor Nominal Group Responses

Question	Student -consistently cited themes across states	Question	Mentor/preceptor – consistently cited themes across states
What were your main feelings on the first day?	Anxiety	NA	NA
What were your main feelings on the last day?	Relief, sadness, confidence	NA	NA
What were the most important things that helped you settle in?	Supportive staff, having peers present	What were the most important things that you did to help students settle in?	Orientation and Introductions
What were the major barriers to you settling in?	Unsupportive staff, lack of preparation (student and facility), >anxiety	What were the main barriers to helping students settle in?	Time
What were the most important things your preceptors did to make you feel you could reach your learning objectives?	Encouragement, support and acknowledgement of individual needs	What were the most important things you did to make students feel they could reach their learning objectives?	Encouragement
NA	NA	What were the main barriers to make students feel they could reach their learning objectives?	Time
What showed you that staff were aware of what tasks and roles you could undertake on prac?	Inconsistent staff knowledge and awareness	NA	NA
What sort of activities did you engage in while on placement in the aged care facility?	Showering and Activities of daily living	What sort of activities did the students you mentored engage in while on placement in the aged care facility?	Activities of daily living
What kind of experiences were you hoping for?	Learning to be a RN	NA	NA
What were your main feelings working with residents?	Sadness	NA	NA
NA	NA	What were the main things you did to prepare students for working with residents	Explanations of resident needs & health, and introducing students

Question	Student -consistently cited themes across states	Question	Mentor/preceptor – consistently cited themes across states
What were your most difficult aspects in working with residents?	Communication	What did you think were the most difficult aspects for students working with residents?	Inexperience of students and resident behaviours
What aspects of this placement contributed to our development as a nurse?	Understanding holistic nature of care	NA	NA
What were the least useful aspects of your clinical placement that contributed to your learning?	Menial activities rather than working with RN	NA	NA
What do you think RNs do in an aged care facility?	Medications, leadership/ responsibility and documentation	NA	NA
NA	NA	What were the main strategies you used to supervise students when working with supervised practitioners?	No common
NA	NA	What were the main barriers to effective supervision of students?	Time
NA	NA	What were the main benefits of having student sin the facility?	Extra hands to help, resident benefits of having more people around
NA	NA	What were the main problems with having students in the facility?	Time

The above table is presented in a manner that aims to provide the reader with easy means of comparing the similar questions asked of student and mentor/preceptor participants in the nominal groups. The consistently stated themes are themes that were outlined in at least one nominal group in every state, meaning that the themes presented are themes applicable to all four states, strengthening the argument of these themes as being typical nationally. In fact, the ease with which common themes fell into most questions is quite remarkable. When compared for analysis, the nominal groups for each participant type were remarkable similar and the team developed strong overarching themes from each question of the nominal groups.

Overall there were 53 student participants in the nominal groups, and 55 Mentor/preceptors (28 PCAs, 7 ENs and 20 RNs). It is most interesting to note that the manner of responses provided by the students are very relationship dependent, as opposed to those of the

mentor/preceptors which are functional and even task oriented, with little focus on the emotions and relationships that are so important to the student participants. However, anxiety and effective measure to effectively decrease it were undoubtedly highlighted as a major factor impacting student experiences of placements.

The responses from the DONs (N=21) to the nominal group questions have been presented separately and follow in Table 17 below.

Table 17: DON Nominal Group Responses

Question	DONs' - consistently stated themes across states
Who are the key staff who take responsibility for the students?	Nurses, DONs, Clinical nurses/nurse managers
What are the most important things that you did to help students settle in?/What does your policy set out as a strategy to help students settle in?	Orientation and planning
What are the main needs of students on placement?	Welcoming/supporting environment and structure
What are the main costs involved with having students on placement?	Time
What are the main ways that student placements are organised?	Limited organisation, uni initiated
What are the main ways you determine the appropriate number of students?	Situation dependent on size, staff skill mix, dependency of residents
What are the main strategies you used to prepare staff for the arrival of students?	Memos, meetings
What are the main benefits of having student sin the facility?	Staff development and reflection
What are the main problems with having students in the facility?	Time consuming
What are the main strategies you use to prepare residents for the arrival of students?	Resident meeting, introduce at time of arrivals

The DON responses demonstrated a predominantly managerial position in student placements. They raised similar points to mentor/preceptors, such as consistently stating time management, organisation and support as important to positive placements.

Additional Nominal Group Data

Additional to the data above, the student and mentor/preceptor nominal groups were also asked questions regarding the amount of time spent with staff of varying roles. The information is highly informative, as seen below in Table 18.

Interesting to note in this table was the percentages of times that students and an individual mentor/preceptor, or students and nurses spent together. There were outliers in two states as their universities had clinical teachers to attend to the students, whom students included as mentor/preceptors in the nominal groups. The data in this table shows that students worked mainly with PCAs and not consistently with any single mentor/preceptor.

Table 18: Time Spent with Mentor/Preceptors / Students

Question	Student	Mentor/preceptor
How much time did you spend with the students?	NA	21-40 + 41-60
What percentage of time did you work with the same mentor? Same student?	0-20% x3, 21-40% x1	No common
What percentage of time did you spend with RNs?/did the students spend with an RN?	0-20%	No common
What percentage of time did you spend with ENs? did the students spend with an EN?	0-20%	0-20
What percentage of time did you spend with PCAs? did the students spend with a PCA?	Vast amount of time	61-80

Discussion

The context of nursing students' clinical placement experiences is, inevitably, that they have multiple stresses in their lives when attending the placement as many are working, studying, and holding family responsibilities concurrently. Just attending the placement at the stipulated times can be a stressor and under-preparedness undoubtedly has the potential to compound this, and to lead to learning limitations. In the case of these aged care clinical placements, the students involved in this study tended to go into the setting with negative attitudes and with expectations so unrealistic that they spent the early days of the placement feeling shocked and overwhelmed.

Also, at least some students were acutely aware of the vulnerability and loss of dignity of residents, as well as the difficulties of communal and, therefore, somewhat regimented living. This caused students distress; they needed direction as to how to deal with these issues.

This burden fell mostly upon the facility staff who also felt under-prepared. There was the potential for this burden to be increased when there was poor communication between university and facility staff, for example, when students did not arrive in an area when they were expected. Also, because the existing staff workload comprised providing resident care, an increase in this workload had the potential to disadvantage residents too.

The one theme that was common to students and facility staff was 'room for improvement'; this refers to a need to improve preparation for clinical placements and may be regarded as an all-embracing theme. If preparation was improved, even in the context of the existing resources, student, staff, and resident experiences would also benefit. This finding resoundingly confirms that of the prior work undertaken by Robinson et al. (2005) and Abbey et al., (2006)

The staff theme of 'facing competing needs' tends, if anything, to understate the stresses faced by facility staff when students attended for clinical placements. They felt under-prepared to meet students' needs, some felt that their role was not valued, some RNs may have felt threatened by the level of theoretical knowledge possessed by the students, and some PCAs felt that students failed to value their skills. One of the things that students wanted to gain during the placement was an understanding of the theory-practice link; PCAs and

students alike perceived that this understanding was unlikely to occur when a student worked only with a PCA. Students also noted that RNs were seldom involved with the provision of direct care so they were unavailable to model that direct care for students. The implications for students' perceptions of the RN role, are clear, and may account for at least one student not wanting to get involved in "dirty work". It is of concern that RNs were seen to have very limited "caring" roles during these clinical placements. There is also a quandary in the clinical placement situation in that students need nurturing and guiding by the facility staff, but they also need to see residents receive good care and being similarly nurtured. However, staff members have their workloads increased when students are present. Even though the students undoubtedly, themselves contributed to the well-being of residents, the very fact of their presence may have also limited staff members' capability of providing high quality care. Despite the increase in staff workloads, however, there were positive outcomes for staff from the placements; staff felt rewarded when students developed knowledge and skills and sometimes became more motivated to update their own knowledge.

In summary, analysis of the data suggests the placements were organised in a reactive and not a proactive way, with inadequate student and facility staff preparation. This could be to the detriment of students, staff and the residents.

4. Trial of the Supervision and Placement Activities Log

It is as well to begin the presentation of the latest development work on the Supervision and Placement Activities Log (SPAL) by recalling the outcome of the systematic literature review which constituted Stage 1 of the Modelling Connections project. After a comprehensive review of the literature on clinical placements the report to DoHA concluded that

‘such propositions as were advanced on this topic [of the conduct of clinical placements in nursing] lacked the support of high level evidence and were generally narrow in scope.’

As stated at the beginning of this report, the systematic review findings have provided the direction for the work being reported here and for work still in the planning stage. In particular, it has led to an increased focus on the production of scientifically robust forms of evidence and the research and evaluation tools that produce such evidence.

In a field of practice where policy is frequently based on established habits and preferences constrained by pragmatic accommodations to local circumstance, the move toward evidence based models and a culture of continuous quality improvement can expect to encounter obstacles. The research team’s supposition, based on practical experience, is that the strongest evidence will be needed to mount a case for change.

Accordingly, the following section of this report records our developmental work on a robust instrument for recording the pattern of the actual expenditure of time spent in clinical placements. The log provides a record of;

- the types of health care workers who supervise and/or are involved in activities with nursing students attending a clinical placement in residential aged care; and
- the activities in which the students are involved during placement.

The Supervision and Placement Activities Log (SPAL) was originally developed in Tasmania as a part of the ‘Building Connections in Aged Care’ study (Robinson et al., 2005) that preceded the current project. The work reported here aimed to trial and refine the log to ensure its feasibility for use in future research into clinical placements, and its reliability and validity.

The report of this phase of the developmental work concludes that:

the current version of the log shows good feasibility, reliability and validity that can be improved upon by minor coding changes, the use of a sample completed card within the facilities, and enhanced education sessions.

The next phase of our research is to test the draft evidence-based/best practice model for clinical placements that has been developed during this study (see Chapter 6); and for that phase it will be essential to have a reliable and valid log that it is feasible for students to use which will enable a determination to be made of what activities students actually engage in during aged care placements. This information is essential to the development of clinical placements in ways that meet students learning needs. The value of the log is not confined to advancing Modelling Connections, of course. Part of the point of a standardised and validated tool is its availability for others to use in assessing the effectiveness and efficiency of local practice.

Methodology

The steps of the methodology for log testing and refinement included the following:

- Step One** Research team review of the existing log (Draft One) and refinements to this log based upon that review.
- Step Two** An expert panel review of the refined log (Draft Two), leading to further refinements.
- Step Three** Trialling of this, next version, of the log (Draft Three) with a group of nursing students attending an aged care clinical placement in two WA facilities, leading to penultimate log refinements.
- Step Four** Trialling of Draft Four of the log with a second group of WA nursing students on placement in the same facilities, leading to recommendations for final refinements.

The methodology and findings for the log trial are reported separately, as dictated by convention. However, the headings of Step One through to Step Four will be used in both of these sections to facilitate clarity in reporting.

Step One: Initial research team review of the existing log (Draft One) and refinements to the log based upon that review

The existing version of the log (termed Draft One for the purpose of this study, see Appendix 9) comprised size A4 documents. Time periods for the entry of codes were of one hour and students were directed to code supervisors/activities that accounted for more than 60% of that hour. The code entry cards were each divided into five working days. There were ten supervisor codes, described as 'direct' (working with) and 'indirect' (supervising or observing but not working with), and 14 activity codes. The first review of the Draft One log occurred at the meetings of the Chief Investigators (CIs) for the project in Queensland on September 1st and 2nd 2005, and again at the meeting in Tasmania on February 9th and 10th 2006. When the WA team had attended to the refinements required, the revised version was again sent to all CIs for additional checking, but no more changes were required. Some further, minor revisions were also carried out by the WA team when preparing the log for the next step of the process.

Step Two: An expert panel review of the refined log (Draft Two) and further refinements based upon that panel review

For Step Two, five experts in the area of aged care nursing, nursing practice clinical placements in aged care, and/or questionnaire development were contacted and asked to review the (Draft Two) log. Using a tool developed for instrument review (Mastaglia, Toye, & Kristjanson, 2003), panel members were asked to assess the clarity of all items, the extent to which each item was appropriate for use in the tool (including whether or not any items were redundant), and the formatting/presentation of all items. Additional comments, such as the need to add items, were also invited. Materials for the panel review were e-mailed as attachments. (see Appendix C-Draft Two log, Appendix D-panel review letter, Appendix E-panel review information sheet, Appendix F-panel review consent form, Appendix G-panel review directions, and Appendix H-panel review form). The completed review forms were sometimes e-mailed back and sometimes sent in hard copy.

A WA team meeting was held to discuss the expert panel recommendations. Four out of five panel members needed to agree that each item was clear, appropriate for use in the tool, and

presented appropriately for the item to be retained in its current format. Appropriate changes were made and the CIs were notified of these.

Step Three: Trialling of Draft Three of the log with a group of nursing students attending an nursing aged care clinical placement in WA

In Step Three, nursing students from one University attending two residential aged care facilities (RACFs) for their clinical placement were recruited and asked to complete the Draft Three log, a demographic details form, and a survey form using which they provided feedback about the use of the log. This University uses Clinical Supervisors (CSs) to work with students during their clinical placements when student numbers in the setting justify this, at a ratio of one CS to eight students for six hours per day. For each of the RACFs in this trial, CS support for students was provided.

Preparation for this Step was as follows:

- a. Steering Committee Meetings were held with the Directors of Nursing (DONs) of each of the two RACF partners to discuss the practical implications of the log trial process within their facilities. Dates and times for staff and student education sessions about the log trial were arranged at these meetings.
- b. Staff information sessions were undertaken by the Project Manager, at each facility. Key staff members were made aware the log trial would be taking place. Staff members were informed that they would have no responsibility for the log trial but would need to be aware that the students would be documenting their activities and the types of staff with whom they were working, using a form that was being trialled. Information sheets were supplied to the facility to be distributed to staff who could not attend the information sessions. (see Appendix N).
- c. Two Research Assistants (RAs) were employed for this Step, one for each facility. These RAs and the three CSs, one for the smaller facility and two for the larger, were provided with an education session and information sheets (see Appendix O) by the Project Manager regarding:
 - the purpose of the log trial,
 - their role in the log trial,
 - the role of others in the log trial, and
 - the coding process.

Any of these individuals who were unable to attend the session were mailed out an information package and were contacted by phone to arrange a time for a teleconference to cover the details of the log trial and clarify their role. This teleconference took place the following week.

The role of each CS was to distribute the cards daily, remind students during breaks that cards should be updated, refill the dish of chocolates provided for students to enjoy while completing the logs, collect the cards daily, check the codes students entered against students' actual activities and supervision/co-workers, and provide the results of this checking to the RA each day during an interview held at the end of their shift(see Appendix P-Clinical Supervisor information sheet, Appendix Q - Clinical Supervisor consent form, and Appendix R-Daily CS/RA interview checklist). For this purpose, they were employed for 30 minutes per day for the project in addition to their supervision hours. The CSs are only funded by the University to work 6 hour shifts rather than the 7.5 hour shifts worked by the students. For the purposes of the log trial, CSs were asked to work these hours from 0700-1300, with students only completing the logs within these times so entries could be checked by the CS.

The role of each RA was to go to the facility each day to collect the cards and determine, during the interview with the CS, the extent to which students doing the same activity or being supervised in the same way by the same type of staff member were coding these events in the same way. Similarly, they needed to determine the extent to which all events were being validly coded by each student, and if there were any feasibility issues. Packages provided for the RAs included a daily CS/RA interview checklist for each day(see Appendix R) and the student feedback surveys to be completed on the last day of the clinical placement (Appendix K).

- d. Students were sent letters and e-mails at least two weeks prior to the beginning of their placement requesting their participation in, and details of, the log trial. Contact details of research team members were supplied for any queries about the research. (see Appendix S-student notification letter).
- e. Research Assistants were contacted by telephone on the first day of the placement to ensure their attendance at the facilities.
- f. Printed log response cards were colour coded to distinguish among facilities in case of any queries. Pastel colours were chosen to ensure easy visibility of entered data codes. Size A6 log cards were placed in a clear A5 plastic protector sheet for attachment to uniforms with a safety pin with a protective lock (a nappy pin). Coding cards were size A5 but laminated. Pens were supplied with each log.
- g. The Project Manager attended each facility on the orientation day (first placement day) to provide students with information about:
 - the study background,
 - the purpose of the log trial,
 - their anticipated role in the log trial,
 - the roles of others involved in the log trial, and
 - the coding process

The education sessions lasted between 45 and 60 minutes. Each code was explained to the students, research team contact details were supplied for any queries throughout the placement, and written informed consent to participation was obtained (Appendix L & M).

- h. Flyers were posted around the facilities as a prompt to students to ensure their log card was regularly updated (see Appendix T).
- i. Spare log cards were placed in the staffroom/nurses' station of each facility in case the CS was absent and unable to distribute the day's log cards. In this instance, it was arranged that the RA would collect the log cards from the students.

The processes for this Step were that consenting students were asked to complete the log cards each day and that the RA visited the facility daily, interviewing the CS about the extent to which students had entered the appropriate codes and marking this down on the RA checklist. Students provided demographic details and completed feedback forms on the last day (Day 9 as this was a 10 Day placement with a public holiday included). Students were presented with certificates at the end of the placement; these acknowledged their participation in a way that could be included in their professional portfolios. At the end of this Step, a meeting was held with the RAs to discuss study process problems that could be resolved prior to the next trial.

Quantitative data were entered into the Statistical Package for the Social Sciences (SPSS), Version 14, and into Microsoft Excel™ (2003). Demographic data were summarised using descriptive statistics. A series of spreadsheets were developed and used to summarise log data; this facilitated the detection of coding discrepancies, for example, when comparing student codes at times of the day when it was known that students would be involved in the same activities. These spreadsheets were developed in several ways: firstly, from case

summaries in SPSS, the output copied into Excel to facilitate a 'user friendly' print out; secondly, from tables of frequencies produced in SPSS, again copied into EXCEL and modified in that database; and thirdly, using SPSS cross-tabulation. The WA research team scrutinised these spreadsheets over a series of meetings and based refinements to the log upon the findings. The refinements were approved by all CIs.

Step Four: Trialling of Draft Four of the log with a second group of WA nursing students

The preparation and processes for the second trial of the log were similar to those implemented for the first trial (see the consent forms, information sheets, and all other forms used in Step Three). This trial was also held in the same RACFs and with students from the same University. However, the education sessions for students (see Appendix U) were further developed based upon the findings from the previous Step and the following modifications were made to enhance the assessment of the tool's reliability and validity and of the feasibility of the tool's use (also based upon the findings of the previous Step).

1. The process now incorporated two specifically designated checks by the CS on student activities, during which they were to observe the students' activity/supervisor during the check and ask the students about these issues for the previous half hour time slot. This would facilitate more comprehensive reliability and validity checks at the end of the shift. We employed these staff for additional project time to facilitate this change and supplied them with activity/supervisor coding cards and a check card for each day (see Appendix V-Draft 4 log, and Appendix W-CS check cards).
2. We also incorporated daily RA data entry checks. The RAs examined the students' coding cards daily, noting any coding inconsistencies. They then attended the students' daily debriefing session and highlighted these inconsistencies to seek clarification from the students. This allowed identification of any misunderstandings that could be addressed by changes to the log and enhanced student education about the use of the tool. The RAs were provided with a prompt sheet for these daily checks (see Appendix X) and informed of coding inconsistencies identified in the first trial to improve their awareness of potential problems.
3. It was stressed to the CSs and RAs that, in the case of absence the research team should be notified, with the aim of organizing other staff to fill the position for that day to ensure consistency during the log trial.
4. Nurses' 'Joey Pouches' were purchased from the Royal College of Nursing Australia for the students. These were designed to clip around the waist of the wearer. Approximately 6 pockets were contained in the pouch for storage purposes. All cards were provided in a size A6 format, which fitted neatly into the pouches. The coding cards, again laminated, were held together by a hinged ring. Pens were supplied with each log. Students were allowed to keep the pouches in appreciation of their participation, and those participating in the first trial were also provided with pouches to ensure equity.
5. Because the log, as used for the second group of students, was found to be, in the main, a reliable tool and one that provided valid data in the context of activities that lasted for the largest portion of each half hour time slot, we calculated preliminary descriptive statistics from the data collected using the log. These statistics summarised the activities undertaken by that group as well as the personnel with whom students were working or by whom they were being

supervised. The analyses that were carried out also led to recommendations to improve the reliability and validity of the tool.

Findings

In a similar format to the methodology section, these findings are presented for Steps One through to Four of the log trial. The modifications made to the log at each of the first two Steps, and which really comprise the findings for these, are only summarised in table format. For Steps Three and Four, the sections include complex findings as well as refinements, or suggested refinements, to the log, the log trial processes, and/or to the processes for the use of the log. Findings for these Steps are reported in the text and the resultant refinements or suggested refinements are reported alongside, in italics. Step Three refinements are also summarised in a table.

Step One: Initial research team review of the existing log (Draft One) and refinements to the log based upon that review

The log revisions detailed in Table 19 (following) were carried out following two meetings of Chief Investigators and a WA team research meeting.

Table 19: Log Refinements for Step One

MODIFICATION TO THE LOG	RATIONALE
HALF HOURLY SEGMENTS INSTEAD OF HOURLY.	SMALLER SEGMENTS FOR DATA ENTRY PROVIDE GREATER DETAIL AND INCREASE THE VALIDITY OF THE TOOL.
ONE DAY PER CARD INSTEAD OF A WHOLE WEEK.	THE SMALLER FORMAT WOULD BE MORE ‘USER FRIENDLY’, FACILITATING FEASIBILITY OF THE TOOL.
INSTRUCTION WAS ADDED TO PUT AN ‘R’ BESIDE THE SUPERVISION CODE IF INDIRECTLY SUPERVISED BY AN RN.	THIS WAS TO SHOW WHEN AN RN WAS SUPERVISING A STUDENT EVEN WHEN THEY WERE WORKING WITH SOMEONE ELSE.
SOCIAL WORKER AND SPEECH THERAPIST INCLUDED IN ‘OTHER HEALTH WORKERS’ CODE.	THESE ALLIED HEALTH ROLES WERE IDENTIFIED AS A MUCH UTILISED RESOURCE IN RACFS AND PREVIOUS ANECDOTAL EXPERIENCE OF TEAM MEMBERS HIGHLIGHTED THAT STUDENTS DO INTERACT WITH THESE HEALTH CARE PROFESSIONALS.
ADD ORAL CARE TO ‘HYGIENE’ CODE.	THE IMPORTANCE OF THIS VARIABLE IN THE AGED CARE SETTING LED TO ITS SPECIFICATION.
NGT ADDED TO ‘MEDICATION ADMINISTRATION’ CODE.	THIS ADDITION IMPROVED COMPREHENSIBILITY.
‘SICK LEAVE’ AND ‘RESEARCH MEETING’ CODES DELETED.	SICK LEAVE WAS SUBSUMED UNDER ‘ABSENT’, RESEARCH MEETINGS WERE NOT REQUIRED IN THIS STUDY.
‘COMMUNICATING WITH RESIDENTS AS A PRIMARY FOCUS’ AND ‘COMMUNICATING WITH RESIDENTS FAMILIES’ ADDED	COMMUNICATION SKILLS ARE AN IMPORTANT PART OF THE CURRICULUM OF UNDERGRADUATE NURSING STUDENTS. COMMUNICATION WITH RESIDENTS WAS

	TO BE CLARIFIED AS AN ACTIVITY IN ITSELF, RATHER THAN ONLY BEING ADDRESSED DURING OTHER NURSING RELATED ACTIVITIES. COMMUNICATION WITH RESIDENTS' FAMILY IS ALSO A FUNDAMENTAL ROLE OF THE RN.
<i>'PROSTHESIS/AIDS (HEARING AIDS)'</i> ADDED TO <i>'ACTIVITIES OF DAILY LIVING'</i> CODE	RESEARCH TEAM DISCUSSION HIGHLIGHTED THIS ACTIVITY TO BE MISSING FROM THE ADL CODE.

THE INTRODUCTORY TWO PARAGRAPHS OF THE ORIGINAL LOG TEMPLATE WERE DELETED	THIS WAS DONE FOR SPACE SAVING PURPOSES. HOWEVER, THE NECESSARY INFORMATION REQUIRED TO ACCURATELY COMPLETE THE LOG HAS BEEN ADDED ABOVE AND BELOW EACH TABLE AS NOTATIONS.
TEXT CHANGED TO SIZE 8 FONT THROUGHOUT	IT WAS DECIDED THE LOG SHOULD BE IN A MORE CONCISE FORMAT, TO ASSIST FEASIBILITY.
'ECA' SUPERVISOR CODE DELETED, REPLACED BY 'PCA/CARER'	IN WA THE TERM 'ECA' IS NOT USED; THE INTERCHANGEABLE TERMS 'PCA' AND 'CARER' ARE USED HERE. THIS TERM WILL AGAIN NEED TO BE MODIFIED FOR IMPLEMENTATION IN OTHER STATES.
'ANOTHER STUDENT' SUPERVISION CODE, TO BE USED WHEN STUDENTS ARE WORKING ON THE SAME ACTIVITY IN PAIRS, WAS ADDED.	THE PILOT STUDY IDENTIFIED THAT STUDENTS SPENT SOME TIME WORKING TOGETHER, THEREFORE IT WAS RECOGNISED THAT THIS CODE SHOULD BE ACCOMMODATED TO SHOW THAT THE STUDENT WAS WORKING WITH ANOTHER FROM THE SAME UNIVERSITY.
MODIFICATION TO THE LOG	RATIONALE
THE EXAMPLE 'TALKING WITH RESIDENTS' WAS DELETED FROM THE ACTIVITY CODE 'DIVERSIONAL THERAPY'.	COMMUNICATING WITH RESIDENTS WAS DEVELOPED AS A CODE OF ITS OWN.
UNDER THE 'DOCUMENTATION' CODE, FURTHER EXPLANATION OF RCS DOCUMENTATION WAS GIVEN.	RCS DOCUMENTATION WAS DESCRIBED AS 'SPECIAL RACF DOCUMENTATION'. IT WAS FELT THIS EXPLANATION WAS NECESSARY AS SOME RESEARCH STAFF AND CLINICAL SUPERVISORS MIGHT NOT BE FAMILIAR WITH THIS TERM.
PHYSICAL ASSESSMENT ASSIGNMENT ON A RESIDENT WAS LISTED UNDER 'UNIVERSITY ACTIVITIES', WHEREAS THE 'PHYSICAL ASSESSMENT' CODE WAS SPECIFIED <u>NOT</u> TO INCLUDE UNIVERSITY ASSIGNMENTS.	AS A REQUIREMENT OF STUDENTS' PLACEMENT IN WA THEY MUST UNDERTAKE A COMPREHENSIVE HEALTH ASSESSMENT ON A RESIDENT. THIS IS DISTINGUISHABLE FROM THE DAY TO DAY HEALTH ASSESSMENT A HEALTH CARE PROFESSIONAL WOULD UNDERTAKE ON A RESIDENT AND CODES REQUIRED CLARIFICATION TO AVOID CONFUSION AND ENSURE VALID AND RELIABLE REPORTING.
THE DESCRIPTION OF THE 'MEAL BREAK' CODE WAS CHANGED AS WE CHANGED THE TIMESLOTS TO HALF HOURLY.	THE DESCRIPTION BECAME 'MORE THAN 50% OF THE HALF HOUR BLOCK'.

Step Two: An expert panel review of the refined log (Draft Two) and further refinements based upon that panel review.

The following modifications were made to the log following examination of the expert panel review responses by the WA research team (see Table 20).

Table 20: Log Refinements for Step Two

MODIFICATION TO THE LOG	RATIONALE
THE WORD 'CODE' WAS ADDED TO THE LOG CARD HEADINGS	THIS WAS TO CLARIFY TO USERS THAT A CODE WAS TO BE LISTED, NOT A NAME OR DESCRIPTION.
THE SUPERVISOR CODE DESCRIPTIONS FOR ALL 'INDIRECT' SUPERVISION WERE FOUND TO BE INCORRECT AND WERE CHANGED FROM 'LESS THAN 50% OF YOUR TIME WAS SPENT DIRECTLY WORKING WITH...', TO 'MORE THAN 50% OF YOUR TIME SPENT INDIRECTLY WORKING WITH...'.	THIS WAS A NECESSARY CHANGE TO AVOID CONFUSION.
A SEPARATE SUPERVISOR CATEGORY OF 'VOLUNTEER' WAS ADDED.	VOLUNTEERS PARTICIPATE IN ACTIVITIES WITH RESIDENTS IN WHICH STUDENTS MAY ALSO BE INVOLVED.
WORDING FOR ALL ACTIVITY DESCRIPTIONS WAS EDITED TO READ IN A UNIFORM TENSE.	THIS WAS TO FACILITATE EASE OF UNDERSTANDING OF THE LOG.
'TOPICAL, EYE AND EAR DROPS' WERE ADDED TO THE DESCRIPTION OF MEDICATION MANAGEMENT.	THIS WAS RECOGNISED AS ANOTHER COMMON ROUTE OF MEDICATION ADMINISTRATION THAT WAS NOT SPECIFIED IN THE EXAMPLE GIVEN.
'MEDICATION MANAGEMENT' WAS CHANGED TO 'MEDICATION PLANNING'.	MEDICATION MANAGEMENT MAY ALSO BE CONFUSED AS INVOLVING THE DELIVERING AND DOCUMENTATION OF MEDICATIONS, HOWEVER, THE NEW CODE SPECIFIED THE PLANNING PROCESS.
'WOUND MANAGEMENT' WAS CHANGED TO 'WOUND CARE' AND THE DESCRIPTION SIMPLIFIED.	WOUND MANAGEMENT MAY ALSO BE VIEWED AS INCLUDING WOUND ASSESSMENT WHICH WAS A SEPARATE CODE.
A 'NUTRITION' CODE WAS ADDED TO INCLUDE NGT AND PEG NUTRITIONAL SUPPLEMENT FEEDS.	NASO-GASTRIC TUBE (NGT) FEEDS AND PERCUTANEOUS ENTERAL GASTROSTOMY (PEG) FEEDS WERE IDENTIFIED AS A FORM OF MEDICATION ADMINISTRATION, HOWEVER, THEY ARE ALSO USED FOR NUTRITION.
A 'FEEDING' CODE WAS ADDED TO SPECIFICALLY REFER TO FEEDING OF DEPENDENT PATIENTS AS OPPOSED TO THE ASSISTANCE OF SET UP AT MEAL TIME IN A PREVIOUS CODE.	IT WAS DEEMED NECESSARY TO DIFFERENTIATE BETWEEN SETTING UP A RESIDENT TO FEED THEMSELVES ('ADL' CODE) AND MANUALLY FEEDING A DEPENDENT RESIDENT WHO IS NOT ABLE TO FEED THEMSELVES. THEREFORE, SET UP OF MEALS WAS MOVED TO THE ACTIVITIES OF DAILY LIVING (ADL) CODE, AND THE 'FEEDING' CODE WAS DEVELOPED.
'PRESSURE AREA CARE' WAS ADDED AS A CODE.	DUE TO THE CLINICAL IMPORTANCE OF ATTENDING PRESSURE AREA CARE IN THE AGED CARE SETTING IT WAS

	DECIDED TO CODE THIS SEPARATELY.
THE ‘DIVERSIONAL THERAPY’ CODE WAS TIGHTENED TO REFER TO PLANNED ACTIVITIES PRESCRIBED BY A DIVERSIONAL THERAPIST.	THIS IS A MORE REPRESENTATIVE DEFINITION OF DIVERSIONAL THERAPY. THE EXAMPLE ‘WATCHING TV’ WAS DELETED.
‘BEHAVIOURAL AND COGNITIVE ASSESSMENT’ WAS ADDED AS A CODE, INCLUDING THE USE OF ASSESSMENT TOOLS.	THE PHYSICAL ASSESSMENT CODE DID NOT ADEQUATELY ENCAPSULATE THE ASSESSMENT OF COGNITIVE OR BEHAVIOURAL DEFICITS.
‘HEALTH ASSESSMENT’ CODE WAS CHANGED TO ‘PHYSICAL ASSESSMENT’.	THIS WAS TO HELP STUDENTS TO DISTINGUISH BETWEEN A ROUTINE PHYSICAL ASSESSMENT AND THE UNIVERSITY SET ASSESSMENT CALLED A ‘HEALTH ASSESSMENT’.
A SUPERVISION CODE WAS ADDED TO INCLUDE ‘WORKING WITH ALLIED HEALTH STUDENTS’.	THE ISSUE WAS RAISED THAT SOME STUDENTS MAY INTERACT WITH STUDENTS FROM OTHER PROFESSIONS THAT MAY BE ON PLACEMENT IN THE SAME FACILITY AT THE SAME TIME.
ORAL ‘NUTRITIONAL SUPPLEMENT DRINKS’ WERE ADDED UNDER THE ‘NUTRITION’ CODE.	A QUERY WAS POSED REGARDING WHETHER OR NOT NUTRITIONAL SUPPLEMENT DRINKS SHOULD BE CODED AS MEDICATION AS THEY ARE SOMETIMES WRITTEN ON A MEDICATION CHART, OR AS A FORM OF NUTRITION. IT WAS DECIDED THIS SHOULD BE CODED AS ‘NUTRITION’ AND THIS WAS SPECIFIED IN THE EXAMPLE TO AVOID CONFUSION.

Step Three: Trialling of Draft Three of the log with a group of nursing students attending an nursing aged care clinical placement in WA

The two facilities implementing the log trial with nursing students in their facility are described as follows: Facility One is a church and charitable organization with 60 high care beds. Facility Two is an approximately 150 bed high care, private facility. A low care facility is located on the premises, however, during the log trial, students were placed only in two high care sections of the facility.

The Semester Three (second year) students were allocated as follows; 42% (8) in Facility One, 32% (6) in one area of Facility Two, and 26% (5) in the second area of Facility Two. All 19 students participated in this trial; 74 % (14) were aged between 17 and 25 years, 10% (2) between 30 and 35 years, and 16% (3) between 36 and 40 years. Less than a quarter of the students, 21%, (4) had worked previously in an aged care facility, all as Patient Care Attendants (PCAs), half of these for more than a year. Nearly two thirds of the students, 66% (12) had never visited a relative in a residential aged care facility.

Assessment of Step Three reliability, feasibility, and validity plus refinements.

Firstly, when data output sheets were scrutinised by the research team to detect any inconsistencies that would indicate threats to the feasibility, reliability and/or validity of the log, discrepancies were noted and refinements were made to eliminate these in future use of the log. These discrepancies and refinements were as follows:

1. Students had coded different supervisors for handover, when they were all in the same room, with the same people, participating in the same activity. This outcome

- demonstrated a threat to the reliability of the log and *changes were made to instruct students to code for all supervisors present during the 'handover' activity.*
2. Some students had coded 'handover' while others had not. This is an activity that students would generally all attend at the beginning of the shift. It might have been that handover was less than 15 minutes of the half hour time slot and, therefore, some students correctly chose not to code it, instead coding the activity that took the longer period, or it might have been that some students attended handover while others did not. This possible threat to the tool's reliability was addressed by *increased emphasis on correct coding of activities in the student education sessions provided for the next Step of the study.*
 3. Working alongside another student was commonly entered. Student data from the same group were compared to identify the pair of students that were working together during that time slot. However, often, either times or activities could often not be matched. *This issue was again addressed by enhancing the student education about coding.*
 4. Students coding of their orientation day was observed to lack detail. Students routinely coded 'orientation' for the majority of the day, although the researchers knew that students were doing specific educational or orientation activities during this time with specific facility personnel. *Codes for these orientation activities and supervisors were developed to provide future students with greater coding options and the necessity of specific coding was brought to the attention of students in the second trial, enhancing the tool's validity.*
 5. Students were assigned code numbers to allow their data to be matched from day to day. However, their entering of this number on the data entry cards and demographic data sheets was inconsistent, with some documents missing codes and some having other numbers inserted. *For future use, Study Participant Numbers (SPN) were printed on students' log cards and the CSs were asked to distribute the cards appropriately.*
 6. The research team expected students to complete the tool for a consistent period, that when the CS was on the premises, yet there was variation among students as to when they recorded. Upon checking, it was found that CS attendance was also irregular in some instances, and that some students had completed the log for their whole shift rather than only when the CS was on site. For the next trial, to ensure clarity and consistency, *students were asked to complete the log routinely for the whole shift.*
 7. On the occasions where students had coded 'other nursing activities', or 'other', they had failed to annotate in the comments section the specific activity that had been performed, as had been requested by the research team. Hence, this accounted for a small portion of 'missing' data. *This issue was addressed in future education sessions.*
 8. From student notations in the comment section regarding regular activities that were being undertaken, it became evident that additional codes could be created to increase detail of the coding process and accuracy of the data collected. *This involved adding codes for the activities of 'debriefing' and for direct supervision by the CS.*
 9. The code 'R' to indicate RN supervision when working with another staff member was never used. *This issue was addressed in the education session.*

Secondly, when examining the students' feedback, the following findings were noted:

Students mainly identified no problems in filling out the log cards, however one student stated that she/he found this stressful. Further explanation of reasons for, or

circumstances behind, this was not provided. Students stated they were not able to fill the log cards out as they undertook activities, but did this every two to three hours in slack periods or breaks. Some students suggested hourly time slots instead of half hourly to alleviate this problem; however, others preferred the half hourly time slots. Some students also suggested 'log completion' breaks to be initiated for students at regular set intervals. Students commented that a lot of the coding throughout the shift was repetitious but that this corresponded to the repetitious routine of work in an RACF. Students described the coding process as easy, however, one student suggested a tick box system to avoid looking for codes. It was suggested that a code for debriefing should be incorporated as this was a fundamental daily activity of the placement. Students requested smaller log cards (eg. pocket size), with no sharp edges of laminate. It was commented the log was, overall, well designed. Students appreciated the chocolate supplied for them to enjoy whilst completing entries. *Changes resulting from this feedback for the next Step of the project were the inclusion of a debriefing code and the use of a Royal College of Nursing Joey Pouch for each student to use to carry the log with them (details of the Pouch are shown in the Methodology Section for Step Four).*

Thirdly, when the team examined the feedback from the RAs and CSs, the following issues were noted:

These staff felt that the completion of cards when CSs were absent showed that students found the task easy and were keen to contribute to the study. The daily interview sessions between the CS and RA demonstrated 100% confirmation of students' coding. However, the project team had found coding discrepancies so this incongruence raised concerns that validity and reliability checks were not sufficiently stringent. *Therefore, two new checking processes were developed (again, details are shown in the Methodology Section for Step Four).*

Prompting was said to be needed to ensure that the students completed the coding, this was provided once or twice per day by the CS. The need for this prompting was reported to diminish as the placement progressed and the students became fluent with the codes; they also need to refer back to the coding cards less, later in the placement. However, CSs noted that when there was a change in students' routine, students required extra prompting at that time. Also, after students were briefed regarding the log trial on the first day, the CS played an important role in being available to reinforce the process and answer any queries students had after the research team member had left. It was also commented that facility staff/DON knowledge and support of the log trial assisted with positive reinforcement of the processes for the students.

It was commented that students were unsure of how to code urinalysis and measuring Blood Sugar Levels (BSLs). *Urinalysis was subsequently added into a code*, however, measuring BSL was an existing code that appeared to have been missed by students and CS. *The inclusion and location of the urinalysis and BSL codes was emphasised to the students in the next Step at their education session.*

It was reported that students were able to identify the link between research and evidence based practice because of the log trial, which assisted them in achieving required competencies for their clinical placement. Chocolates also seemed to be an important 'reward' for the students and students had also commented to the CSs that the participation certificates they received were a valued recognition of the students' efforts.

The RAs reported that students requested smaller coding cards and that some students did not wear their coding cards on them all the time, as was intended, because they found them too big and not completely waterproof. *This reinforced the need for the Joey Pouches.* The RAs also felt that preparation was the key to facilitating student involvement in the project, along with repeated reinforcement of the research project requirements by CSs, RAs, and DONs/facility staff. It was believed that the RAs, through their daily meetings, played a supportive role for the CSs throughout the trial. .

Amendments to the log and the trial process are summarised in Table 21 below. Most were directly derived from the findings; a few more improvements were made because it became evident that these would also improve reliability, validity, or feasibility.

Table 21: Log and trial refinements resulting from Step Three

REFINEMENTS	RATIONALE
'FACILITY EDUCATION' ACTIVITY CODE WAS ADDED.	TO FACILITATE MORE SPECIFIC CODING OF ORIENTATION DAY ACTIVITIES A 'FACILITY EDUCATION' CODE WAS DEVELOPED. FOR EXAMPLE, MANUAL HANDLING WAS SOMETIMES COVERED BY FACILITY STAFF AT THESE SESSIONS. INCREASING THE SPECIFICITY OF CODING TENDED TO INCREASE THE VALIDITY OF THE TOOL.
'DEBRIEFING' ACTIVITY CODE WAS ADDED.	IDENTIFIED AS MISSING BY STUDENTS.
'CS' SUPERVISOR CODE WAS ADDED.	AN OVERSIGHT IN THE INITIAL REVISION TO THE LOG, PERHAPS BECAUSE OTHER STATES PREVIOUSLY USING THE LOG DO NOT EMPLOY CSS, WAS THAT DIRECT SUPERVISION BY A CS WAS NOT INCLUDED.
'FACILITY MANAGEMENT' CODE WAS ADDED.	THIS WAS TO MORE SPECIFICALLY CODE THE ORIENTATION SESSIONS.
ENHANCEMENT OF STUDENTS' EDUCATION SESSIONS: STUDENTS ASKED TO CODE FOR ALL SUPERVISORS PRESENT DURING 'HANDOVER', ALSO CORRECT CODING EMPHASISED AND EXAMPLES GIVEN, INCLUDING PROVIDING DETAILS WHEN CODE STATES 'PLEASE SPECIFY'.	FROM EXAMINATION OF PREVIOUS CODING ISSUES.
ACTIVITY CODES WERE GROUPED DIFFERENTLY.	THIS WAS TO IMPROVE FEASIBILITY.
'NGT FEEDS' WAS PRESENT IN 2 CODES, SO WAS REMOVED FROM THE 'OTHER NURSING ACTIVITIES' CODE AND LEFT IN 'NUTRITION'.	THIS WAS DELETED TO AVOID CONFUSION AND THEREFORE IMPROVE THE VALIDITY OF THE TOOL.
STUDENTS TO BE INSTRUCTED TO FILL OUT THE LOG FOR THEIR ENTIRE SHIFT.	THIS WAS TO AVOID CONFUSION AND ENHANCE CONSISTENCY OF REPORTING.
STUDENT PARTICIPATION NUMBERS (SPN) WERE ENTERED ON RELEVANT TRIAL DOCUMENTS INSTEAD OF ASKING STUDENTS TO ENTER THESE.	THIS WAS AGAIN TO AVOID CONFUSION AS WELL AS TO ENHANCE ASSESSMENT OF RELIABILITY AND VALIDITY.

Step Four: Trialling of Draft Four of the log with a second group of WA

Nursing students

This group of Semester Three (second year) students, from the same University as those involved in Step Three, were allocated as follows; 42% (8) in Facility One, 32% (6) in one are of Facility Two, and 26% (5) in the second area of Facility Two. Again, all the students consented to participate in the study. Of these students, 79 % (15) were aged between 17 and

Chapter 4: Trial of the Supervision and Placement Activities Log

25 years, and 20% were in the more mature age groups. Forty seven percent (9) of the students had worked previously in an aged care facility, 78% (7) of those students as PCAs and the remainder as catering or domestic staff. Of these students employed in the aged care setting, 11% (1) had between 6 and 10 years of experience, 44% (4) had between 1 and 5 years of experience, 33% (3) had worked for less than six months in the area, and one student did not answer the question. More than half, 58% of students (11), had never visited a relative in a residential aged care facility. This clinical placement was for 10 days.

Assessment of reliability, feasibility, and validity plus possible future refinements

Firstly, when we examined the log entries, the following findings were noted:

As is more fully explained later, some students had (mistakenly) written down the activities that they were carrying out as well as coding them. Therefore, we were able to check the extent to which these activities were accurately coded. Twenty coding cards from 200 were fully completed in this way (10%). All 540 entries on these cards were checked and a total of 61 codes had been incorrectly entered (11.3%), meaning that the activity coding was 88.7% accurate. It was, however, not possible to check the coding for the supervisors/co-workers in this way. For reliability checks, we looked at all the log entries from 11 of the 19 students (58%) for instances when students had reported working with one other student. There were 63 such instances, and in 62 of these the students had both specified the same activity at that time, demonstrating 98.4% agreement in the coding, this supporting the reliability of the tool. We omitted the other 8 students in this check because these students had been mistakenly advised to code being in the same room as another student as working with another student.

Specific orientation activities were coded by students, as was the anticipated aim of some of the coding revisions between trials. The researchers were aware of some activities undertaken on the orientation day at these facilities, so were able to check these with the student coding. Specific activities/supervisors included in orientation day coding included orientation by facility management, orientation by CS, University activities by University staff (log trial education session), and orientation ('seek and find') with other students. These findings support the validity of the log. Another coding issue was that the code 'R', showing RN supervision when working with another person, was again never used. *This code, therefore, should be deleted from the tool.*

The 'handover' activity was accompanied by coding for several supervisors, as was instructed by the research team. There was some confusion about whether to code 'direct' or 'indirect' supervision for these supervisors. The research staff had specified 'direct' coding was applicable, however, for the purpose of accounting for who was in attendance with the students during this activity, both forms of coding would deliver this information. Some discrepancy was noted with the number of supervisors students coded. The CS was left out by some students and the student code was included by some. The occurrence of some students coding handover while others did not was only evidenced by one student on two occasions, demonstrating increased log reliability when compared with the previous trial. *It would probably be simpler to code the multiple 'supervisors' for handover using a separate code.*

When coding a 'meal break' activity, there was confusion over the coding of a supervisor. While some students left this code blank, the majority of students coded 'another student' as their supervisor during this time. The CS was also occasionally coded. *It needs to be specified that no supervisor is required to be coded when on a meal break.*

Double coding of supervisors was generally discouraged because it complicated data analysis and was rarely likely to be appropriate, but working with another student was sometimes entered alongside working with the CS. *It may be appropriate, therefore, to code joint student sessions with the CS separately.*

From the evidence of miscoding shown when comparing activity descriptors with codes (which was minor) it became obvious two particular codes seemed to be used if students could not find the correct code, or did not know where else activities would fit. *These codes were 'other, please specify', which could be deleted because almost all activities specified*

fitted elsewhere, and 'activities of daily living' a code which could be split into more specific sub-sections for clarity.

Occasionally, students were coding two activities in the one time period. The occurrence of this was matched to two students, and diminished in the second week of the placement.

The following codes are valid activities highlighted by the students that do not fit within any of the existing codes, yet are practiced by students in the aged care setting. The fact that only three of these codes are recommended highlight the substantial feasibility of the tool to date. The codes that need adding are *physiotherapy, please specify; case conferences; and massage. The addition of physiotherapy, however, requires the deletion of 'range of movement exercises'.*

Secondly, when we examine the student feedback, these findings were documented:

Two ethical issues arose. The first was that a student commented that she/he had felt obliged to participate in the study, despite knowing that it was a voluntary activity and having received study information and signed the consent form. The second was that two students described the log completion as taking too much time and effort and therefore detracting from their placement experience *These issues require the consideration of the project team concerning the inclusion of students in further projects and with a view to further emphasising the voluntary nature of participation and the fact that students can discontinue their participation if this is their wish.* In contrast, there were some very favourable comments about the use of the logs in that they were said to act as a prompt for activities and as a record of achievement.

With reference to the logistics of using the coding card, students requested greater room for coding as there was not enough room for coding multiple supervisors. *A refinement that would address this issue without taking additional space on the code entry card would be the addition of a non-specific code for multiple supervisors. If this was restricted for use in the handover slots, the lack of specificity would not be an issue as all staff usually attend these sessions routinely.* Dropping a coding digit was also suggested by a student but this would result in a loss of information conveyed by the code.

Students also expressed concern that they were only able to code one activity per time slot, so that the log fails to capture a range of procedures that take students only a short period to perform. *Some students suggested 15 minutely time slots to allow this data to be recorded, which would certainly improve the tool's validity, but would reduce its feasibility.*

Another suggestion was that students should be allowed to create their own codes, which is probably a suggestion already covered by student nomination of 'other' activities. Also, it was said that students were reluctant to use the code 'doing nothing'. *A code such as 'awaiting appropriate supervision' could be incorporated to alleviate this concern and ensure accurate coding.*

In most cases the chocolates were well received. However, some students *suggested healthier options and alternatives for students with lactose intolerance.*

Thirdly, when we examined CS and RA feedback, these findings were noted:

On three days, the CS was absent and not replaced. On these days, the daily CS/RA interview did not take place. However, on the remaining days, the CSs gave 100% confirmation of student activities as logged.

As in the previous trial, it was felt that prompting was required by the CS for students to complete the log. One CS also took the time on Day 1 to read over the coding cards again with the students. Further prompting came about from the new daily RA data entry checks. It was felt that the new CS spot checks also reminded students to complete their log cards. The requirement for prompting students was felt to be greatly diminished by the end of the first

week as students became familiar with the codes and the coding process. There were a few instances where students had taken log cards home rather than giving them in for examination by the CS, which meant that the validity and reliability checks for those students on that day were compromised.

Some students described to the CS difficulty coding an instance when they were educating the resident and the residents' family at the same time *a coding issue that requires consideration*. The CSs also indicated that students felt it was difficult to decide what activity to code if they had spent exactly 15 minutes on each task. It was commented students found the nurses' Joey Pouches useful and that they were valued.

Fourthly, when we examined the data from the new RA data entry checks, we documented the following:

It was found that students rarely coded handover as this often went for less than 15 minutes. When students did code handover, they often coded the CS as being their supervisor, despite being asked to code all those staff members attending handover. *A statement on the code sheet and an example of a completed log card would clarify this issue but, again, a special code for the multiple people present during handover might be appropriate..*

It was discovered that RAs had sometimes asked students to write a specific annotation of their activity in the comments section of every time slot, to make the RA data entry checks 'easier', which was not a requirement of the research team, but, according to the RA, students were happy to do this. Although this provided useful data for validity checks, *this was an impediment to feasibility and future projects must ensure that this is not asked for again*.

By the end of the first week, the RAs indicated that students found coding to be easy. Some students, however, left the facility early, either coding this time as absent or leaving the time blank. *This is an issue to rectify by mentioning it in education sessions*.

When students were experiencing conflict over which of the two activities they had spent equal time doing to code, they were instructed by one RA to code the 'newest knowledge gained' activity. *To ensure consistency, the refined log must specify what the requirement is in this situation*.

The RAs found that students working together had occasionally coded different times, perhaps because they were relying on recall. Upon discussion between the students these times were rectified. It was also noted that coding 'working with another students from the same University' caused some confusion for the student. Students were not sure whether to code this co-worker if they were in the same room but working independently on differing activities. In one facility, they had, incorrectly, been advised to code this as if they were working on the same activity. *These data were excluded from reliability checks and, in the final version of the log, clearer directions and a sample completed card should avoid similar misunderstandings*.

Fifthly, when we examined the data from the CS' reliability and validity checks, the following findings were noted:

Two CSs were unexpectedly absent on a total of three days therefore spot checks were not completed on these days, however the RA still attended the facility and completed their daily data entry checks with students.

When codes entered for students by the CS were compared to the codes entered for the same periods by the same students, several flaws were found with the CS documentation, these rendering the checks invalid. (i) CSs were to observe the student in one (30 minute) time period, however some had documented a one hour period, making comparisons with student data impossible. (ii) Several students (up to 8) were noted as being observed performing different tasks at the same time, which would seem to be virtually impossible. (iii) Upon

observing the student, the CS was also to question the student regarding their activity and supervisor for the previous period (ie, the half an hour before), however, often the confirmation entry time was after the observation entry. (iv) Sometimes, CSs noted specific times and not time periods and the confirmation check was also at a specific time within the same time period. (v) There were occasions when the CS had not entered a time period. (vi) Some CSs listed codes that did not exist on the coding key. *If such a validation exercise is attempted again, a far greater degree of staff education and support will be required. Also, research rather than clinical staff would be more suited to this role.*

Finally, when we examined the descriptive statistics developed from the log data, the following findings were noted:

Table 22 below shows the extent to which students worked directly with facility nursing or care staff and/or the CS, under the indirect supervision of these individuals, and/or alone or with other individuals. Whenever a CS was on the premises, it was assumed that they were indirectly supervising the students (when not directly working with them) and students were not required to code this. For the most part, the supervisors were on the premises for 6 of the 7.5 hours, on each day of the clinical placement. All percentages shown in the table were calculated after deducting entries recording student absences, which accounted for 10.6% of all entries. Footnotes (c) and (e) indicate where there was still some confusion with coding in two respects - during meal breaks and when working alone but close to another student from the same University. The problems with coding for the meal breaks meant that students sometimes indicated that they were working with another student when they were on a break; there were also a few occasions when students indicated that they were working with others at this time. In the main, though, this issue means that students were not working with other students from the University to the extent that is shown in the table. The problem with coding that they were working with another student occurred when some students indicated that they were doing this when they were in the same room as another student but undertaking a different activity. This problem will again mean that the figure shown in the table as 'working with another student' will be an overestimate; it also means that the figure for 'working alone' will be an underestimate. Most obviously, students worked little with facility staff, and much more either with the CS, other students, or alone.

Table 22: The Two-Week Student Placement: Supervisors and Co-Workers (% of entries)*

ROLE	INDIRECT SUPERVISION (%)	DIRECT SUPERVISION OR WORKING WITH (%)
CLINICAL SUPERVISOR^A	12.1	10.6
REGISTERED NURSE^B	0.5	2.9
ENROLLED NURSE	0.8	0.5
CARER (PCA)	6.3	3.0
STUDENT (SAME COHORT)^C	N/A	30.9
STUDENT FROM ELSEWHERE	N/A	0.2
	With others	
OTHER HEALTH CARE WORKERS	2.0%	
UNIVERSITY STAFF MEMBERS^D	3.8%	
FACILITY MANAGER	12.8%	
	Other responses	
WORKING ALONE	6.3%	
MULTIPLE SUPERVISORS OR CO-WORKERS	2.7%	
NO CODE PROVIDED^E	4.6%	

Note:*Students made entries for each 30 mins according to how the main part of the 30 mins was spent

- a) Indirect supervision shown for CSs was calculated by determining when the students indicated they were alone and the CS was on the premises. This does not include the time when the CS was on the premises but other staff were working/indirectly supervising the student
- b) The Clinical Supervisor was not included as an RN in the coding system
- c) Approximately 12% of the time that this code was provided was for meal breaks. Also some students provided this code when they were in the room with other students but working alone.
- d) University staff members were project staff; Clinical Supervisors were not included here
- e) More than 90% of the time that this code was provided was for meal breaks

Table 23 below shows the extent to which students worked on the various activities within the facilities. All percentages were calculated from the time remaining after student absences. There was only one concern with the coding for these activities. This was that 'other activities, please specify' (Code 224) was mainly used by students when documenting a variety of activities that were already clearly covered by other codes. The only previously uncoded activities entered here were massage, physiotherapy (possibly, as only range of

movement exercises were covered by Code 203), 'house supervision', and attending a case conference. A couple of concerns arise from these log entries, in that the physiotherapy referred to might not be something suitable for nursing students to undertake (depending upon the specialist education required for the activity), and, potentially more seriously, 'house supervision' would seem to indicate that students have been left to supervise aged care residents when on their clinical placement. University activities and hygiene are the most common activities shown.

Table 23: The Two-Week Student Placement: Student Activities (% of entries)*

Activity	%
Handover	2.7
Hygiene	18.5
Activities of daily living	5.2
Feeding	8.4
Nutrition (other than oral feeding)	2.5
Pressure area care	0.2
Wound assessment	0.7
Wound care	2.4
Medication planning	1.0
Medication administration	4.2
Observations	0.8
Documentation	1.9
University activities (includes physical assessment as set by University)	15.9
Orientation	4.7
Debriefing	8.6
Facility education	1.9
Diversional therapy	1.9
Physical assessment (but not set by the University)	0.6
Behavioural/cognitive assessment	0.1
Communication with residents as a primary focus	2.8
Communicating with residents' families	0.3
Other nursing activities	1.4
Non nursing activities	0.4
Other activities (specified)	2.0
Doing nothing	0.2
Meal break	9.7

Note: *Students made entries for each 30 mins according to how the main part of the 30 mins was spent

Reinforcing previous recommendations for refinements, those that are suggested by these descriptive findings are that it must be clearly indicated on the coding sheet and using a sample completed coding card that meal breaks should not be accompanied by a code for a supervisor and that coding another student as a 'supervisor' should only occur when the student is working with another student. These directions also need to be reinforced at education sessions and by any project support staff. Also, again as previously specified, the code for 'activity, other, please specify' should be deleted and consideration should be given to deleting any reference to physiotherapy elsewhere and adding 'physiotherapy, please specify', 'massage, please specify', and 'attending a case conference'.

Discussion and Conclusion

In this project, the research team set out to trial and refine the Supervision and Placement Activities Log to ensure its feasibility for use in future research into clinical placements and its reliability and validity. The log has been revised in many ways during the project and findings have also led to recommendations for final refinements. There is no doubt that the use of the log in future research into nursing students' aged care clinical placements will provide important study data that is both reliable and valid, or that the log is feasible for student use. The discussion that follows will address the main study findings regarding the tool's properties and the processes involved in its implementation with a view to providing a clear picture of how the log should be presented and used in future research. Further research to address reliability and validity issues is not addressed here although there are also some clear lessons that may be learned for this project in this respect.

The feasibility of using the log for nursing research depends upon the simplicity and clarity of assigning log codes and documenting them, the extent to which this process can be achieved in just a few minutes, and the portability/accessibility of the tool. The codes have been shown to be almost entirely comprehensive, a situation that will be improved even further when the minor additions recommended from the second log trial are implemented (adding codes for physiotherapy 'please specify' [but deleting reference to physiotherapy elsewhere], providing massage, attending case conferences, and attending joint student sessions with a supervisor. A special code for multiple supervisors when attending handover might also be helpful but the code 'R' should be deleted as it was never used.

The speed with which coding is currently achieved is clearly acceptable to most students. The current size of the log documents and the Joey Pouch used for carrying these mean that feasibility of use is considerably enhanced.

The validity and reliability of the current format of the log have been well demonstrated in the second trial reported here but will undoubtedly be enhanced further by providing a few clearer directions on the coding cards, in education sessions, and in sample completed logs, regarding only coding students as 'supervisors' when engaged together in the same task and not coding a supervisor for meal breaks. This issue, does, however, raise yet one more. This is that the use of the term 'supervisor' for brevity also causes some confusion. It may be appropriate to review this term. Deleting the code 'activity – other' will also improve the tools validity as it will 'force' more accurate coding. Replacing 'doing nothing' with 'awaiting appropriate supervision' might also remove a impediment to honest reporting as students have indicated that they feel uncomfortable reporting doing nothing. Coding in 15 minute blocks would also enhance the tool's validity, but this needs to be considered in relation to the tool's feasibility and reliability also. The log would then take the students longer to complete. Also, they are only completing the documentation every two to three hours, relying on memory, so reliability and validity might also, conversely, be compromised by more mistakes in time recollection if this option was pursued. There is some evidence that errors already occur because of mistaken time recollections. The issue of choosing how to code an activity that has

taken exactly half the time allocated for the time slot, however, must be addressed by stating this on the coding card and at education sessions so that a reliable (consistent) approach is taken.

The processes involved with trialling the log were complex. The ethical issue of students feeling bound to contribute to a study in which their university is involved needs careful consideration. Also, it is clear that support is needed for students to use the tool even when validity and reliability are not being assessed, to ensure that it is used as it should be. Students require education sessions but also an on site person who is knowledgeable about the log of whom to ask questions. Consideration needs to be given as to how this may be achieved. Students also need encouragement from those around them and in terms of incentives (such as snacks provided to be enjoyed when completing the tool, certificates of participation, and being able to retain the Joey Pouches). Students' appreciation of such items demonstrates their need to be recognised as valued participants in a project.

In conclusion, the current version of the log shows good feasibility, reliability and validity that can be improved upon by minor coding changes, the use of a sample completed card within the facilities, and enhanced education sessions.

5. Overview

The first purpose of this section is to review the evidence presented in the preceding chapters and to deal with some of the questions that arise from it.

How representative is the sample and the evidence?

Location:

Twelve facilities spread across four States were recruited to the study – six in Tasmania and two in each of the other States - and the distribution of the study's staff and student respondents across those States is shown in the table immediately below.

Table 24: Staff participants by state

STATE	SA	TAS	WA	QLD	TOTAL
RESPONDENTS	22	29	33	23	120**

**In some cases this group of staff, comprising RNs, ENs and PCAs, was supplemented by 12 DON respondents, all of whom were RNs.

Ownership:

As shown in detail earlier, the sample was not precisely representative in this respect. No government-operated sites were included in the sample. The charitable or not-for-profit sector was overrepresented but one large private for-profit RACF was included. There is no reason known to the research team to suppose that this aspect of the sample's profile would have distorted the results obtained in this project.

Size:

The dozen RACFs had a total of 1042 beds, and the arithmetical mean size was 87 beds; whereas, considering all Australian RACFs as a whole, the average number of places in a facility is 53. Our sample had fewer small RACFs than the overall Australian RACF sector; it was close to matching the national average proportion of mid-size facilities; and it had more large facilities than the Australian industry as a whole. On that basis it would appear that our sample sites are broadly representative of facilities likely to be used as major training sites.

Level of care:

Not surprisingly, perhaps, given the purpose behind the selection of sites, the sample was also rather more likely to offer a mix of high-and low-care beds than is found across the whole Australian industry profile, probably with a view to offering a wider range of experience of different levels of care than a random selection would probably have achieved.

Staffing:

As noted earlier, our sample spans the spectrum from quite small to quite large facilities, and so caution is appropriate for the usual reasons associated with averaging across a diverse sample. That said, the staff profile, the ratio of RNs to other grades of staff in the 'average' sampled site is probably reasonably indicative of standard practice across the sector.

Conclusion:

The project team's original goal was 'an in-depth study of the experience of enough undergraduate nursing students enrolled in enough different universities who had undertaken clinical placements in enough different facilities in enough different states to give us some grounds for confidence that what was found in the research would be likely to be found in any similar inquiry in a selection of other facilities around Australia.' All in all, it seems fair and reasonable to conclude that this goal was met and that the data arising from the study is more broadly based or representative than might reasonably have been expected of a study using the available resources.

What does the background data on the RACFs and their staff tell us about the present training capacity of the sector?

To raise the question is in no way to diminish the effort that is made in the facilities we studied or in those others of which the research team has direct experience. The burden of this report's conclusions relevant to this question is that the scope for improvement is at the strategic level, in improved coordination and a commitment to clearer communication. At the same time, having outlined in the Introduction to this report the team's conception of the present moment in the development of 'clinical education', it follows that the question must be asked in the interests of creating a culture of continuous quality improvement throughout the sector in respect of on-site training and mentoring.

The staff profile found in the RACFs, where the majority of staff are part-time and/or casual employees is not of itself a promising ground on which to build a training operation in which a rounded mentoring function, requiring a good level of familiarity and continuity is required. The dominant role in care provision of the PCAs and the students' impression of the RN's role in RACFs – 'she never gets her hands dirty' – also is less than an ideal training context and model for the aspiring RN. The educational history and lack of training experience, as well as the absence in so many cases of any formal requirement to give training and supervision is also another reason to query the part that mentoring and training in general plays in the facilities' day-to-day mission. We might also interpret the general staff uncertainty about so many aspects of the orientation program, as shown in the Orientation Experience Survey, as indicative of a reduced role within the facilities' culture for training and education.

How prepared, equipped and motivated then are RACF sites to provide a practical clinical training experience at the level required to match contemporary standards in higher education and the care needs of the current and future RACF population?

No definitive conclusion can be reached based on the evidence assembled in the course of this research. A fuller, more focused study would be needed. Notwithstanding, it would appear highly likely that:

- the present training burden is considerable and the outcomes presumably thought important by the various health professions represented among the site visitors;
- the training function does not appear to have as high a profile in the mission thinking of the facilities as one might expect;
- the staff mix and profile, relevant aspects of which have been detailed, is not such as one would design for the purpose we are discussing;
- in relative terms the staff are not well prepared by their education history or postgraduate training for the role they are, in some cases, expected to play;

- while the volume of training provided is high, there are many health disciplines notable by their absence. The nurses are the only university level students who attend aged care facilities in numbers.

It might seem a fair interim conclusion to say that the quality of training and mentoring actually achieved is reasonable relative to the level of the inputs available to the staff and management of the RACFs.

What conclusions and concerns emerge from the comparison of staff and student reports of the Orientation Experience?

As noted earlier the orientation questionnaire was based on a similar instrument used in the Building Connections in Aged Care Project (Robinson et al. 2005). The content was intended to mirror the project's conception of a soundly conceived, well delivered and well absorbed orientation experience.

In other words a high percentage of 'Yes' answers from the two groups, the staff and the students, and a high level of agreement between them, would provide the project team with persuasive evidence that the orientation was appropriate to the students' needs and that the staff were adequately prepared for and committed to the process. In turn, such evidence would lead the researchers to conclude that any shortcomings in the quality of the clinical placement experience as a whole were unlikely to be due to an incomplete or poorly-performed orientation process.

Conversely, a perceived failure to cover the items during orientation, or to leave any of the parties uncertain as to whether or how they were covered, would indicate that, to say the least, a better preparation could have been afforded to the arriving students.

Second, if there were to be a patterned difference in the questionnaire responses of the staff and student groups the team would be led to query the processes employed to transmit the information. Such questioning might lead on to an examination of either or both the adequacy of the concept of clinical education embedded in the university school or in the facility's lived culture and/or the institutions' capacity to deliver it at the appropriate level. That is precisely the focus of this part of the Modelling Connections project.

As we saw in Table 13 (pages 34 – 35) the skewing of the responses is consistent. Staff confidence in the transmission of the required knowledge is always higher than among the students. For the purposes of aiding investigation, it may be worth speculating on what circumstances could have given rise to these patterned disparities; but for the purpose of reporting it is quite sufficient to note that, on the evidence, staff were a lot more satisfied that the orientation process was achieving its objectives than the students were.

As stated previously, no member of the research team has heard discussion in RACFs or among RACF staff of the kind of phenomenon detected by a comparison of the groups' responses. No published evidence of this phenomenon has been identified in the systematic review that preceded this stage of the Modelling Connections study. Management and staff in the RACFs making up the study sample were unaware of the discrepancies, as were the clinical facilitators in the universities. However it is interesting to note that similar results were found in Stage 1 of the Building Connections in Aged Care project (Robinson et al. 2004a), where staff consistently rated the effectiveness of their teaching practices higher than students.

It seems to the research team reasonable to infer from the novelty of the report issuing from this part of this study that there must be some questions about the adequacy of the quality assurance practices in use within the RACFs and within the universities. Unless it can be

convincingly argued that the results presented above would not have been obtained in other times or at other places, one inevitably meets the question: why have they not been found before? Answers might be found in the absence or failure of quality assurance mechanisms applied to the orientation process; and in the absence or failure of feedback and debriefing practices both within the RACFs and the universities.

The levels of staff uncertainty and ignorance of the orientation process as carried out in their own workplaces must surely be seen as evidence pointing to a need to raise the profile of orientation activities among all staff. Positive change in this matter is likely to require strong leadership and possibly, some help from the university sector.

As concerning as anything else emerging from the data is the potential danger that lies in areas such as managing the fire risk, the professional's legal and ethical duty of providing effective and timely care and legal liability in the areas of occupational health and safety. The matter would appear to be a serious one for both service providers and universities.

What does the qualitative evidence presented in Chapter 3 show?

In conclusion, the qualitative findings of this study demonstrate that the clinical placements undertaken by students involved in this study resulted in some good outcomes for students, facility staff, and residents. However, there were also significant stresses identified for all three groups of individuals that could undoubtedly have been addressed, at least to some extent, by improved preparation for the placement. Some very specific recommendations emerge from these findings.

The first recommendation that emerges from the team's reflections on thematic analysis of the transcripts is that students undergo a period of preparation for aged care placements that precedes the placement and includes explication of the reality of the aged care situation. Some of this preparation needs to be experiential rather than just knowledge based. For example, students could be introduced to older people in hostel settings during a social occasion to get accustomed to being with very elderly people and could also meet some of the residents within the placement facility on a social basis before going there on placement. A variety of other teaching-learning methodologies should also be used within the university, prior to the placement, to explore and, where necessary, rectify students' understanding of communicating with frail older people, including people with dementia; continence issues; extreme frailty; and death within an aged care facility. Students also need to be prepared to adapt their learning to the situations in which they will find themselves within the aged care setting, for example, working with a carer. They may be able to use resources such as books and worksheets to help link theory to practice when they cannot access clinical educators, ENs, and RNs.

The second recommendation is that staff within the facilities should also undergo a period of preparation for student placements. They need to know what the objectives of the placement are and how they can assist in ensuring that these objectives are met. These staff members also need to know the boundaries of their roles and to be assisted in setting priorities so that they feel less pressured by the placement experience. Most of all, they need to understand that the students are likely to be apprehensive about the placement and to be put at their ease so that they may learn more easily. Questioning of clinical practice should be accepted as a legitimate student learning practice rather than an implied criticism. Staff members need to be aware that the modelling of good care needs to be the priority.

The third recommendation is that the university's liaison with the clinical setting has to be exemplary. Ideally, consistent staff will be involved in this process and short, disruptive

placements (that are also less helpful to students) will be avoided. Students should be made aware that they have an obligation to meet normal work requirements of arriving on time, informing the relevant person about sick leave, and so on. All processes should be clearly documented and that documentation should be easily accessible. Residents and their family members should also be informed about the clinical placement, which should minimize anxiety about the presence of many strangers in the setting, promote understanding when care takes a little longer than usual, and may allow students to feel accepted more quickly.

A final recommendation is that student debriefing is made available on each day of the clinical placement. Students in the aged care setting undoubtedly need this resource in order to understand and come to terms with the many new and challenging experiences that occur.

In summary, our findings have indicated that students, staff, and residents will undoubtedly benefit by a revision of aged care clinical placements. This revision should be centred on improved preparation for the clinical placements improved communication processes, and opportunities for student debriefing. The implementation of these study recommendations could be expected to yield the benefits already mentioned, but also make it likely that the profile of aged care nursing will be enhanced rather than denigrated by the placement experience.

6. The Draft Evidence Based/Best Practice Model for Quality Clinical Placements in Aged Care

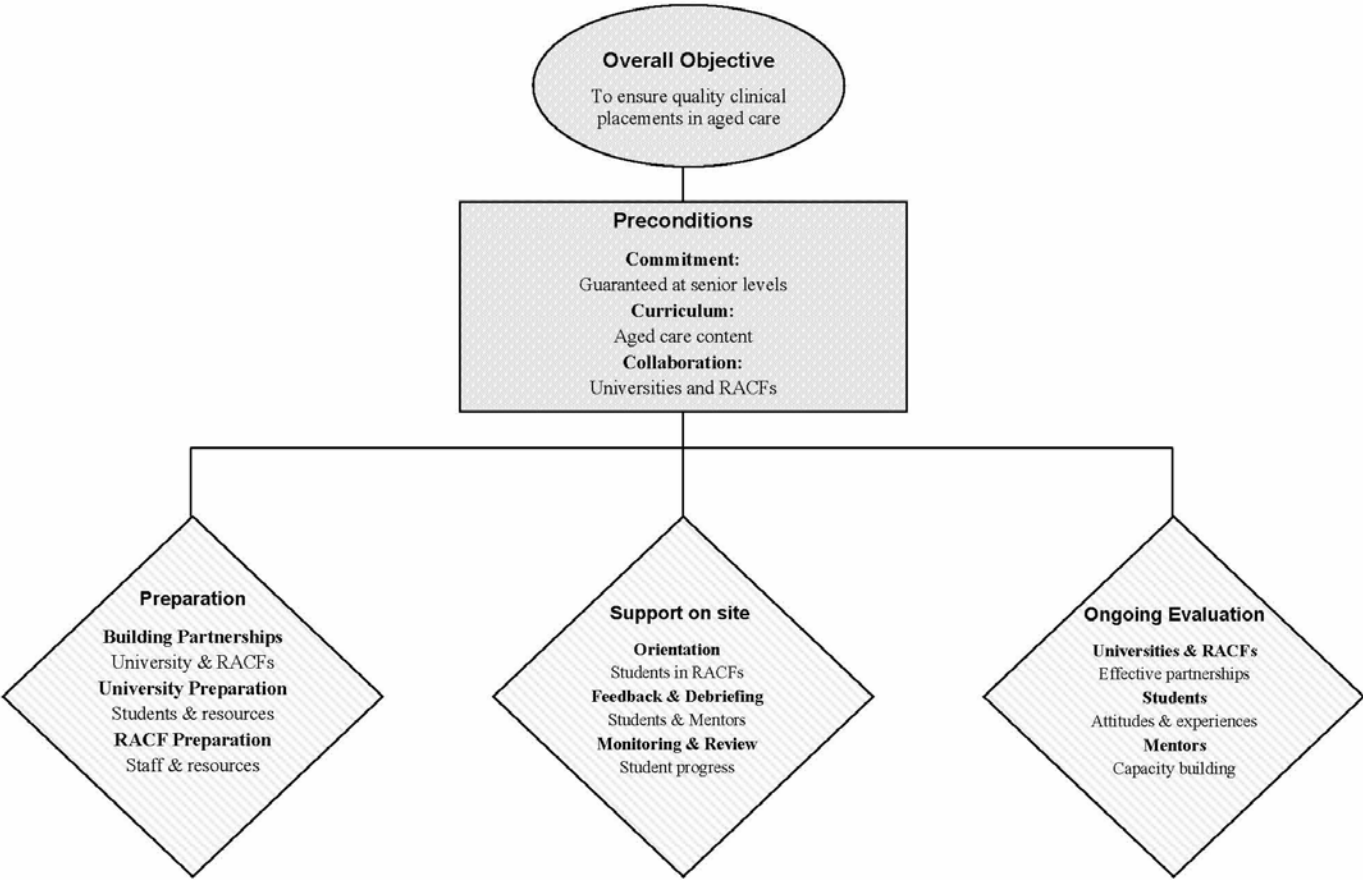
**Guidelines for implementation of the
draft evidence based/best practice
model for clinical placements in aged
care**

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Introduction

Figure A: Diagrammatic representation of the Draft Evidence Based /Best Practice Model



About the Manual for the Draft Evidence Based/Best Practice Model

Preamble

The goal of the Modelling Connections project is to produce a comprehensive draft evidence-based /best practice model covering all the steps necessary to the introduction, maintenance and ongoing evaluation of a standardised model for the conduct of quality clinical placements for undergraduate nursing students in aged care settings.

The current developmental phase builds on work done in Tasmania and, to a lesser degree, in Queensland over several years. The recently completed systematic review of the literature on the subject was sufficiently broad to allow the project team a high level of confidence in relation to the project's acquaintance with the available evidence.

On that basis some commentary must be offered on the extent to which the successive steps of the Model offered here can boast a reliable evidence base. As the project has unfolded it has become increasingly clear that:

- there is a lot of writing bearing on the issues involved in clinical education in nursing;
- the body of research is uneven with regard to its coverage of the field, with some topics covered many times and others almost completely ignored; and
- the evidence on the issues, whether it be plentiful or sparse, is almost always of the kind ranked as low-level on account of how it has been gathered or assessed.

The team can claim to have done a good deal to sift and order the available evidence, to map areas of concentration and of neglect, to rank the evidence for its scientific quality and to extract from it firm guides to action. The draft evidence-base of the Model, as set out in the associated Manual, has all the characteristics outlined above. If the project is able to proceed it will employ a strategy capable of producing Level II evidence which can be applied across a very wide range of settings, with the consequence that prescriptions for practice can be issued with a high degree of confidence that the forecast results will follow.

For the present however, it must be accepted that practice will continue day-by-day regardless of the quality of the evidence available to support it, even oblivious of whether or not any such evidence exists. Given this, the team has constructed a model to cope with the necessary steps in the process and to do so in ways that take appropriate account of the difficulties and setbacks that are reported in the literature. The best available evidence, whether or not it meets the most rigorous scientific criteria, has been attached to the various steps and processes making up the Model, and the actions and their evidence base detailed in the Manual.

A 'Users' Guide' to the Manual & Draft Model

This Manual explains the rationale and objectives of the draft evidence based/best practice model shown graphically above. This note explains the structure of the document and how to navigate through it, making appropriate connections.

As Figure A, on page 80 shows, there are four distinct, sequenced steps in the overall process:

1. 'Preconditions' refers to preliminary steps that are recommended as necessary to forge a new partnership between the industry and the schools of nursing in the preparation and accreditation of student nurses;
2. 'Preparation' deals first with the work that must be done with students in the university before they begin their clinical experience; it then focuses on the work that must be done within the RACFs with management, staff, residents and their families;

3. Support in the site' covers the measures that must be implemented and the climate that must be cultivated if student and staff collaboration in practice and learning about practice is to be as fruitful and stimulating as it could be. This includes 'de-briefing', a stage that has a vital part to play in assisting the students and staff to find meaning in their experience and to reflect on how that meaning may relate to any preconceptions they may have had.
4. 'Evaluation' is a key step in the process of continuous quality improvement inasmuch as, effectively carried out, it gives every participant a chance to make known their assessment of the experience and the grounds on which that assessment rests. Ongoing evaluation is integral to the model and its assessment of how successful implementation has been as variables will change across facilities and across time.

'Actions to be taken' are listed and explained for each Area. The evidence base (or other considerations) on which the significance of the Area and/or the recommended Actions rest is indicated by cited item numbers keyed to the Reference List at the end of this booklet.

AREA OF FOCUS & RATIONALE

1) Preconditions

Contemporary change management principles suggest that the first steps should focus on:

- gaining and publicising commitment at the CEO and board level to the concept of an ongoing, periodically reviewable partnership between the training institutions and the employing industry that is supported by the funding source(s);
- ensuring that the intended curriculum to be delivered by the partnership meets research-based best practice standards; and
- ensuring that the necessary structures and processes to implement and maintain the partnership are understood and accepted by the parties and endorsed by the funding source(s).

ACTIONS TO BE TAKEN

PARTNERSHIPS NEED MOMENTUM

1a. Prepare brief introductory memorandum as foundation for negotiation and adoption of partnership status by university and industry leaders, with government participation and endorsement.

1b. Universities and industry representatives to sign off on minimum terms for formation and operation of partnership for specified term with provision for interim monitoring and reporting [A mini-version should be enough for the trials phase].

CURRICULUM

1c. Ensure undergraduate course meets requirements outlined in the QUT 'Aged Care Core Component in Undergraduate Nursing Curricula - Principles Paper'.

1d. Ensure the undergraduate curriculum and undergraduate teaching ensures a positive image of ageing and emphasises the particular specialist skills needed for this work.

EVIDENCE BASE

1a. At least 11 studies [20, 23, 28, 35, 40, 46, 55, 56, 58, 72, and 80] explicitly deal with the need for improved collaboration between the educational institution and the clinical placement provider, the consequences of failing in this area and some strategies that can be employed to achieve the desired goal of collaboration. The building of closer and mutually supportive relationships, the foundation of what should be a partnership, is seen by some observers as necessarily extending into the management chains of both agencies and should include supervising/otherwise-involved university academics on the one hand and, on the other, the onsite nursing staff of all grades. Patterns of collaboration varied from a case study involving a high degree of integration of clinical staff into the university's teaching program [20] with some joint appointments and teaching becoming part of the clinicians' normal role; to the provision of some training for facility staff by academics in recognition of their cooperation [40]. A couple of broader plans and theoretically conceived models worth further attention were located and these can be found by reference to items [55 and 58].

1b. The need for closer collaboration between the higher education and healthcare institutions are identified in items 103, 105, 108, 114, 116 and 117 as are the tangible benefits likely to accrue to both sides of the partnership [111]. Item 120, a 2005 South Australian parliamentary committee report, usefully notes the converse, viz. the problems and tensions arising from the different missions, circumstances and weekly/annual timetables of the not-always-whole-hearted partners.

1c. An Australian government-commissioned study carried out by a team of nurse researchers from QUT has recommended that 'aged care content should be a significant compulsory component of the undergraduate nursing curriculum' (2004:4). They add that positive role models and ageing messages are essential, as are partnerships between universities and RACFs. Essentially, aged care content should be of equal status with other clinical areas in undergraduate degrees. The QUT paper sets out the principles that need to be included in aged care curriculum content. Other sources indicate the importance of aged care content [103]. Happell [16] indicates that a curriculum focused on acute care will highlight that aged care is not a desirable option for students to work in. This is repeated by Pearson et. al., [54] who show that educators can positively or negatively influence students' interest in aged care. Other studies [61, 65] also discuss the need for aged care content in an undergraduate curriculum.

1d. Item 20 demonstrates how a re-designed undergraduate curriculum, change to integration of education-clinical service relationship and involvement of all practitioners in clinical supervision after special education and training program resulted in high (84%) rating for possible career in mental health nursing and high positive rating for quality of placement and teaching supervision. This information applies directly to aged care nursing placements.

Pearson et al [54] indicate that, as well as curriculum reform undergraduates need

- increased exposure to aged care topics and experience;
- more positive experiences in aged care environment and issues surrounding healthy ageing; and use of appropriately qualified teachers (with aged care experience); and
- advanced education for staff and education for unregulated workers reduces stress and can impact on capacity to support students in aged care.

In item 55 there was evidence to show that there is a symbiotic relationship between curricula, clinical education and transition (p12 & 13).

AREA OF FOCUS & RATIONALE

2) Preparation

The evidence indicates that many students find aged care confronting and contrary to their expectations on several fronts and the arrangements between Universities and RACFs are often inadequate. Therefore preparation should focus on:

- University and RACFs collaborating on preparation;
- lessening students initial shock at confronting old, frail bodies, dementia and death; and
- deepening students and preceptors/staff/mentor's understanding of student needs.

ACTIONS TO BE TAKEN

BUILDING LINKS AND CREATING COLLABORATIVE MECHANISMS

2a. University staff to identify appropriate/preferred RACFs which will provide an optimum environment for successful student placements. University to ensure more available RACFs than required for student numbers in case of facility drop out. Contractual arrangements must include appropriate number of students negotiated for each facility.

2b. Arrange placement 3 months prior commencement.

2c. Clinical facilitator, with expertise in aged care and a commitment to excellence in clinical education, appointed by university to coordinate placement.

2d. Individual RACFs identify Key Contact Person (KCP) who will be responsible for optimum preparation and organisation of placements and make collaborative arrangements with this person and University staff.

UNIVERSITY BASED PREPARATION OF STUDENT AND RESOURCES.

It is important that RACFs have access to a toolkit (as will be developed in Stage 4 of Modelling Connections proposal). Adapted in consultation with RACF stakeholders, that will inform and assist staff in RACFs to effectively support students, and that students are adequately prepared for aged care placements.

2e. Development of an information toolkit.

Examples of what a Toolkit may include:

- Numbers of students
- Names of students
- Year group of students
- Learning objectives of students
- Dates of student commencement/completion
- Arrangements of clinical facilitator – how they will make contact with the RACF, contact details, their role and responsibility
- Discussion of the models/components such as time out for students and mentor/preceptors for completion of evaluations, and debriefing

- Prior learning and clinical experience
- Student scope of practice
- Guidelines for student practice
- Learning objectives of students related to their specific unit of study and their course structure
- Students required assessments such as episodes of practice and clinical inquiry
- Learning strategies for students

2f. Students participate in a pre placement session run by clinical facilitator and university academic staff to prepare students for the aged care placement. Examples covered may include:

- What to expect whilst in a RACF on placement
- Dementia care, frail bodies and death
- Implementation of a decision making framework, i.e. working with various staff members including PCAs, delegation, responsibility, accountability, supervision and scope of practice of students and various staff members
- Infrastructure support for students on placements.
- Single day session for all students in the facility before their clinical placement

FACILITY PREPARATION – PLACEMENT ORGANISATION AND RESOURCE DEVELOPMENT

It must be recognised that there will be a variety of arrangements relating to aged care placements in various RACFs. If there is a clinical teacher employed from an individual RACF, then they take over the role of the KCP. It is also important that mentorship groups are formed which involve key stakeholders who will work with students within each RACF.

2g. Members of the RACF mentorship groups must be appropriately prepared in order promote quality placements. This may include clear directions for the following:

- Allocation of students to work areas.
- Organising student professional development sessions ie manual handling.
- Developing student rosters.
- Ensuring that students are able to contact an RN mentor/preceptor at least daily.
- Education sessions for mentors/preceptors.
- Preparation for the arrival of students such as:
 - Informing all RACF staff of impending student placements, on notice boards, in staff meetings or newsletters and organising orientation.
 - Conducting formal and informal discussions with all staff regarding the students' role and prior experience.
 - Targeting PCA mentor/preceptors who will work with students under nurse supervision.
 - Developing or making available information packages for students that address RACF general information, routines and resident needs.
 - Roster development - the mentorship group aims to place students in the same area as much as possible, and have them working with RN mentor/preceptors and other mentors as much as possible.
 - Promoting to staff the importance of students to the facility.
 - Developing formal mechanism for university academic staff and RN mentor/preceptors to gain feedback from other mentors.
 - Placing student rosters on noticeboards in relevant areas, i.e. the area in which each student will be working.
 - Informing staff of date of student arrival and completion dates.

Chapter 6: The Draft Evidence Based/Best Practice Model for Quality Clinical Placements in Aged Care

- Developing aids for students, e.g. a list of residents containing important information and directions to care plans etc for more details, photos and key care issues.
- Mentor/preceptors rostered to work at time of students arrival and as much as possible during the placement.
- Preparation of residents prior to arrival of students.

EVIDENCE BASE

2a. Clinical sites need to be carefully selected in the light of knowledge of the vital signs of a learning organisation and the cultural characteristics that identify such places. Acceptance of a site as a training location must be periodically reviewed based on evidence of how standards and culture may vary over time as a result of unforeseeable events that exhaust the slim buffer that protects most aged care residential facilities from adverse changes [84]. Item 102, describes careful selection of sites and preparation and training of staff. The need to ensure that there are more RACFs than needed for student placements in order to accommodate changes in RACFs management or ability to take students was found to be vital for planning purposes [84]. University clinical facilitators need to be able to allocate students only to very good sites. A brief encounter with a dysfunctional or seriously underperforming clinical site may teach some useful negative lessons; but to spend two or more weeks there during an important stage of one's professional preparation is more likely to blunt one's professional spirit than to hone it.

2b. The three months lead in time is needed to prepare the facility, to share information re students' needs and put in place partnership arrangements [84]. The complexity of rostering to maximise continuity of preceptor–student contact must not be underestimated, especially in an industry with such a high proportion of part-time and casual staff in the workforce [104].

2c. The importance of well trained and informed clinical facilitators is found in level IV evidence and is repeated and sometimes extended in many of the studies rated at the QE level [20, 29, 30, 31, 32, 55].

2d. Evidence [175,84] shows that staff in most facilities have little direct, personal familiarity with the modes and purposes of university education. This highlights the need to have close links between the Universities and RACFs and the need for improved collaboration between the two [20, 23, 28, 35, 40, 46, 55, 56, 58, 72, and 80].

2e. Much evidence concentrates on the general needs of collaboration between RACFs and universities in preparation for clinical placements but few have been specific in suggesting practical outcomes with respect to resources that may facilitate preparation and communication. The suggested toolkit list is based on information from items 84, 85, 175 and 176.

Item 72 describes a model of collaborative teaching where clinicians were given access to a range of facilities by the universities which led to an excellent team building experience. These findings illustrate the importance of collaboration between the university and RACFs in developing resources such as a toolkit. Item 59 describes the need for the articulation of specific learning goals and resources between the university, the student and the RACF.

2f. The need for adequate preparation of students prior to entry into the RACF clinical placements was a frequently recurring factor in the evidence obtained [24, 28, 33, 42, 58, 59, 84, 85]. Careful academic and practical preparation of students prior to the placement's commencement [item 84] is important to address students' anxiety [84, 85, 174,9,43 and 55]. This should include issues such as:

- addressing preconceptions gained in prior contact with RACFs, either as casual employees or as visitors [84, 175];
- adequate orientation of students to the clinical site during/even before the first working visit [59, 85]; and
- preparation of students for the experience of working with older people, people with dementia and people who are dying [84, 85, 175, 176, 177].

2g. Within the evidence there is terminological uncertainty regarding the terms preceptor and mentor. There is a lot of attention paid in the studies to the delineation of the role and its major attributes [e.g. item 29]. Prominent among the qualities and functions nominated are: being an advisor, being a supporter, being a regulator, being a negotiator, being a networker, assisting,

befriending, guiding, advising, and counselling. However, the role may be referred to, defined or portrayed, the studies reviewed leave no doubt that effective mentoring/preceptoring/clinical teaching, for which the teacher is trained and well recognised, is a very significant part of any successful clinical placement for students. E.g. item 26 states – ‘Having a good mentor and reporting a good placement usually coincide.’ This would find support in many of the studies reported. One article [item 49] has urged the general adoption of distinct usages for the terms ‘mentor’ and ‘preceptor’, with the first describing a supportive, educative senior peer – junior peer relationship and the second reserved for a supportive, instructional practitioner – trainee relationship. Others take up the task of clarifying the terms [e.g. item 25] but in fact these terms, as well as others such as ‘clinical teacher’ or ‘clinical practice facilitator’, are used interchangeably by many writers [e.g. item 64]; as we do in this report.

Regardless, the general lack of training for mentor/preceptors discussed in the study samples [20, 31, 55] shows this needs attention, with cumulative training over time the option most likely to be workable. Indeed, our study [175] shows that training roles and responsibilities in RACFs for RNs and other staff are very often not formalised, a situation that compares unfavourably with teaching hospitals used for other nursing specialities. Mentor/preceptors may have apprehensions about working with tertiary students [120], concerns which may be heightened by their age [16] and their length of time in the one sector [175] and even the same facility [175]. The current project and other studies [27] have found that those apprehensions tend to be overcome by experience and that facility staff can find their role in mentoring students professionally stimulating. This is recognised by them as a benefit, the more so because of the degree of professional isolation often experienced in RACF nursing [84].

Other factors raised in this level of evidence included the following:

- Specific education for mentors/preceptors, to ensure that their role is fully understood as a specialised area of teaching, is useful and effective [items 20, 31, 40, 55].
- Mentors need to be clinically experienced and know the area where they are working with students, but at least as much importance must be given to the management of their relations with students in their charge [eg, items 24, 25, 26], especially because of the evidence of anxiety or apprehension aroused in both staff and students [9, 84, 85, 174, 9, 43 and 55] by the clinical placement encounter.
- If possible clinical staff who are simultaneously fulfilling a nursing role and mentoring/preceptoring students must have workload adjustments so as to ensure that they are allowed separate time for student mentoring [25, 30, 32, 60 and 84].

The importance of adequate preparation was a frequently recurring factor in the evidence searched [24, 27, 28, 33, 42, 44, 58, 59, 84, 85] including early, clear and full notice to all parties of student names, placement dates, rostering arrangements, academic staff/coordinator visits, etc [item 84]. Similarly, the provision to all parties – onsite teachers, ward staff, local management, students and supervising university staff - of documentation explaining mentor/preceptor roles, what is expected from students, what their learning objectives are, and so on [27]. Preparation of staff in the clinical area, including those not directly involved in student teaching or supervision, is highlighted as important in order to make them aware of:

- students’ needs, including the need to feel welcome, safe and valued;
- the benefits that come with the site’s hosting of student placements and how to make the most of them [28, 58]; and
- how to overcome/manage any frictions or frustrations felt by any parties [26].

A number of studies highlight perceived benefits for residents as a consequence of student nurses participation in clinical placements [84, 100]. Similarly, a report on recruitment and retention of nurses in residential aged care highlights that meeting residents with different conditions increased the range of learning opportunities in aged care [60], while Robinson et al. (2005) report that students greatly enjoyed their interactions with residents and appreciated the opportunity to work with the same residents over the course of the placement. However, they also note that this had some implications for practice i.e. slowed drug rounds which may have the impact of slight delays

to the administration of resident's medications [8]. Our current study showed that both residents and students had some apprehension about their interactions. The presence of students is clearly seen to have an impact on residents and the evidence suggests they need some preparation prior to the arrival of students, at the very least information about the students and when the placement will commence.

AREA OF FOCUS & RATIONALE

3) Support on site

The evidence indicates that key activities to support students during the placement will assist an optimum outcome. A number of elements are important to continuing the support provided by the best possible orientation once the student arrives at the site. These include:

- Ensuring students feel welcome;
- orientation to sources of information and support;
- familiarising students with the working environment, including the roles of different grades of staff, information on layout and responses to problems;
- explaining the needs and morbidities of the elderly in residential care; and
- providing excellent mentorship and support.

ACTIONS TO BE TAKEN

ORIENTATION

3a. The provision of a comprehensive orientation to RACFs is central to students having a positive learning experience. The KCP coordinates the student orientation to provide support on site, including;

- facilitating a process whereby members of mentorship group are rostered to ensure that as many as possible are available to meet students on arrival to the facility;
- coordination of a formal orientation process and completion of the orientation checklist over the first week of the placement (the orientation checklist provides a guide to the activities to be undertaken in the orientation);
- the allocation of mentor/preceptors to students (RNs EN and PCA);
- formation of mentorship group (all mentor/preceptors and KCP form mentorship group, in liaison with the RACF Director of nursing, they collaborate with university Clinical Facilitator to develop a placement program which will include;
 - allocation of students to work areas;
 - organising student professional development sessions ie manual handling;
 - developing student rosters;
 - ensuring that students are able to contact an RN mentor/preceptor at least daily; and
 - education sessions for mentor/preceptors, organised and run by clinical facilitator.

FEEDBACK AND DEBRIEFING

3b. Debriefing and feedback are imperative in this model. Debriefing is important as it provides students and mentor/preceptors with a safe environment in which they can discuss their experiences, share their problems, develop and share new strategies and develop feedback loops. Facilitating debriefing and feedback involves;

- weekly debriefing sessions conducted for the student groups and for the mentorship groups facilitated by the KCP; and
- participation in debriefing sessions gives both students and mentor/preceptors an opportunity to explore their;
 - experiences working with students / mentor/preceptors; and
 - effective strategies to facilitate teaching and learning; and
 - to identify feedback needed for improvement.

MONITORING AND REVIEWING STUDENT PROGRESS

3c. Discussion between Clinical Facilitator and KCP in response to student or mentor/preceptor feedback; – in conjunction with debriefing sessions, this facilitates prompt response to concerns of the group, or individual participants:

- Clinical facilitator to make contact with students in RACFs.
- Clinical facilitator and KCP to liaise to discuss student progress weekly.

EVIDENCE BASE

3a. It has been shown that one of the most important aspects of making students feel welcomed, and in influencing positive opinions of their placement, is a formalised, structured orientation and welcoming friendly staff [84]. Beitz [7] indicates that organisations must provide good orientation for a clinical facility; use literature to guide facility development and provide useful educational tools to assist mentor/preceptors to provide effective clinical instruction.

Clare, Brown Edwards and van Loon (2003) emphasise the importance of adequate orientation of students to the clinical site during/even before the first working visit [item 59]. Jackson and Mannix (2001) showed that students desperately wanted to perform well and be accepted by hospital staff. Their main findings were that students put great importance on;

- attitudes and behaviours of staff to student clinical learning experience; and
- being friendly, showing interest and explaining was helpful.

They also showed that passive negative behaviour of staff can make students feel unwelcomed, intrusive, and uncomfortable. Clare et al. (2002) discuss the need for;

- appropriate collaborative assessment of students' clinical learning;
- continuing development and use of innovative clinical education models that promote teaching and facilitate learning; and
- responsive evaluation of the clinical learning environment to ensure its adequacy to teach students [59].

Storey and Adams (2002) highlight the importance of implementing a deliberate orientation process which gives prominence to planning and recording student's own learning goals, stimulated via brainstorming the cohort's learning opportunities and discussion of both positive and negative expectations [88].

Mentor/preceptors play a key role in the orientation of students, hence the importance of them being rostered on duty when students first arrive in the RACFs [84]. As well, mentor/preceptor groups have also been found to provide a great deal of support to RACF staff who work with students [84]. Gray and Smith (2000) sum up what many others say; that an effective mentor/preceptor guides, supports, assesses, and supervises students. This role is potentially a source of great comfort to students, as mentors remain a linchpin of their learning throughout practice [26].

3b. Arrangements for the regular and careful debriefing of students during and after their clinical placements are needed. Rogan and Wylie[42] describe the benefits of weekly debriefing and debriefing at tutorials for students who undertook a structured education program attending RACFs one day a week for six weeks. McLeland and Williams [66] describe the negative impact on students when debriefing sessions were withdrawn due to lack of funding. Debriefing opportunities also need to be available for mentors/preceptors to meet short term needs and to harvest their longer term observations [item 27]. The need for arrangements for the regular and careful debriefing of students during and after their clinical placements are also set out in item 27.

3c. Beitz [7] found that preceptors need to act quickly on negative feedback from students, promptly review any observed shortcomings and use a clinical warning notification system to highlight any unsafe student practice and thus contribute to practice development through a continuous improvement model. Timely feedback on performance, offered without malice, condescension or delay in a professional rather than a personal framework is seen as important. As Evans [43] reports, when students receive prompt supportive feedback this alleviates anxiety.

AREA OF FOCUS & RATIONALE

4) Evaluation of the placement

Ongoing evaluation is integral to the draft model and its assessment of how successful implementation has been as variables will change across facilities and across time. Evaluation aims to test students and mentor/preceptors changes in attitudes towards working in aged care and knowledge gained.

ACTIONS TO BE TAKEN

4a. Student Evaluation.

- Evaluation prior to entry
 - Student expectations and attitudes to aged care.
 - Prior experience.
 - Demographics.
- Evaluation at 1 week
 - Orientation.
 - Student experiences.
 - Expectations.
- Evaluation on completion
 - Experiences and attitudes.
 - Evaluation of teaching and learning.

4b. Mentor/preceptor Evaluation.

- Capacity Building
- Teaching and learning.

4c. Universities and RACFs.

- Effective partnerships.

EVIDENCE BASE

4a. The systematic review found no reports of evaluation which would contribute to the success of a model, as differentiated from feedback and debriefing as described in 3.

The report of Robinson, A., Andrews-Hall, S., Fasset, M., Venter, L., Marlow, M., Cubit, K., Menzies, B. & Jongeling, L. (2006) – Building Connections in Aged Care Follow-up Evaluation Report [174], is the only one which reported an evaluation which demonstrated that the introduction of a comprehensive model was effective in showing a change in attitude of undergraduate nurses towards working in aged care on graduation. Robinson et al demonstrated a significant positive change in students attitude indicating a possible interest in working in aged care following graduation.

The importance of including evaluation as an integral part of the model is to ensure that the effect of implementation is continually monitored. For example, staff changes may mean that parts of the model may need to be re-implemented at different points in time [174]. Evaluation as an integral part of the model will ensure that this does occur. The Fourth Generation Evaluation methodology used in the Building Connections project [84] supported the participants' sense of ownership and provided findings which gave pictures of the functioning of the RACFs not previously understood. Positive feedback from the evaluation encourages staff in continuing with the model, negative feedback shows where gaps may be occurring.

4b. The importance of evaluation of mentor/preceptor's work is vital. Some information may be gained through feedback and debriefing, but independent, confidential evaluation must also take place. The systematic review outlines four instruments that have been developed to assess factors relating to characteristics of preceptors relevant to providing quality clinical placements for nursing undergraduate students. The instruments are:

- The Nursing Clinical Teaching Effectiveness Inventory (NCTEI) [items 10, 12 and 7].
- Observations of Nursing Teaching in Clinical Settings (ONTICS) [item 7].
- Clinical Learning Environment and Supervision Scale (CLES) [items 8 and 5].
- Clinical Teaching Survey (CTS) [item 9].

In addition the review found two other instruments that could be useful in evaluation:

- Spielbergers' State Anxiety Scale(S-Anxiety Scale) [9]. Spielbergers' State Anxiety Scale(S-Anxiety Scale) is designed to measure both state and trait anxiety in individuals while undergoing their clinical experience [9].
- Critical Success Factor ratings [13 and 6]. The technical purpose of the study was to identify the critical success factors affecting the transfer of nursing knowledge during clinical practice placements.

The importance of evaluating mentor/preceptor performance is further illustrated in the Building Connections in Aged Care project [84]. It demonstrated the usefulness of evaluating (i) capacity building among staff as a consequence of taking on the role of student mentor/preceptor and (ii) the value of comparing students experience of being preceptored and their mentor/preceptors assessment of their capacity to facilitate teaching and learning. Like the differences in perception related to the orientation process reveal ed in the current project [175], in the latter case the data highlighted discrepancies between the preceptors' perceptions of the situation and those of students [84]. At the same time Item 59 indicates the importance of a responsive evaluation of the clinical learning environment to ensure it adequacy for teaching students.

Mogan and Knox (2002) [10] found that 'Interpersonal relations' was rated very highly as a key area of excellence. The 10 highest ranked characteristics of effective clinical educators as ranked by students were: 'good role model', 'encourages a climate of mutual respect', 'is self-confident', 'demonstrates clinical skill, judgement and clinical procedures and techniques', 'provides support

and encouragement', 'listens attentively', 'helps students make use of practice opportunities', 'demonstrates communication skills and corrects students without belittling them' [10].

Another study [6] found the same and added-attributes/predispositions such as 'treats students sincerely and objectively'; 'treats students as people with thoughts and wisdom'; 'avoids subjectively judging students'.

Item 2 added some further detail to the student perception: highly rated clinical teachers were perceived as aware of the student's level of development, thus recognising the student as an individual with needs specific to a particular point in their learning trajectory; they behaved inclusively, making students feel part of the ward team; and fostered professional and personal development as well as clinical learning. Item 9 showed how positive perceptions of personality/behavioural characteristics *versus* negative ones influence the student's anxiety during their clinical placement;

Item 5 raised other influences that would be important to evaluate, which are 'management style of the ward manager and the premises or governing principles of nursing on the ward.' Abbey et al (2006) found that 'certain residential aged care industry and practices negatively influenced student's experiences' [176]. This information needs to be elicited in a safe and confidential manner.

4c. As has been stated in part 1 of this manual there is abundant evidence to indicate that a vital component of success in clinical placements is the accomplishment or otherwise of the collaborative arrangements and communication between universities and RACFs. Item 106 indicates that partnerships are essential foundations of nursing education and describes models and fundamental principles that should apply to all models for future undergraduate education, especially clinical placements. The importance of collaborative relationships makes it imperative that the nature of these relationships should be evaluated on a regular basis. Evaluation is needed to ensure that the scheduled organisational arrangements do take place and there is a systematic audit of the implementation of the university and RACF partnership agreements eg Is the communication working? Has personnel changed? Do there need to be different arrangements put in place?

Item 105 discusses the need, not only to maintain and improve present partnerships, but to enhance and increase these. Evaluation can assist in this process.

PROPOSED OUTLINE: ROLES AND RESPONSIBILITIES ASSOCIATED WITH THE DRAFT EVIDENCE BASED/BEST PRACTICE MODEL

Clinical Facilitator (CF)

The CF is a University employee(s) who;

- Is an integral member of the unit teaching team
- Is responsible for overseeing all RACF placements
- Liaises with RACF KCP and students,
- Is required to visit individual students on placement at RACFs
- Coordinates and facilitates
 - Pre-placement sessions for students
 - Tool kit development
 - KCP/CT skill development sessions re debriefing and evaluation sessions
 - Mentor/preceptor education
- Is the University contact person.
- The CF must have expertise in aged care (QUT, 2004), not be a general University staff member assigned the role.

RACF Key Contact Person/Clinical Teacher (KCP)

A KCP is a RACF staff member of an individual RACF who

- Is the RACF contact person
- Is responsible for
 - Co-ordination and facilitation of mentorship group
 - Liaison with RACF Director of Nursing
 - Selection of mentors/preceptors
 - Liaison with CF
 - Student and mentor/preceptor debriefing sessions
 - Evaluations
- Ideally this person is in an education or L2 role within their workplace

Clinical Teacher (CT)

A clinical teacher is a RACF staff member temporarily seconded by the University,

- Whose role mimics that of the KCP
- Who additionally to the KCP, works full time and works one on one with the students

In the presence of a CT, a RACF KCP is not required. For this reason the CT's usual workplace must be the RACF.

RN Mentor/Preceptor

A RN mentor/preceptor is a staff member of the RACF who has;

- Undertaken mentor/preceptor education sessions
- Is involved in the mentorship group and
- Takes responsibility for working with students, assessing their competence, assisting them to meet their learning objectives, and is responsible for supervising their work with other mentor/preceptors

EN Mentor

An EN mentor is a staff member of the RACF, who has;

- Undertaken mentor education sessions
- Is involved in the mentorship group and
- Works with students, assisting them meet their learning needs

PCA Mentor

PCA mentors are PCAs in the RACFs, who

- Have undertaken a mentor education session
- Are involved in the mentorship group
- Work with the students as required and assisting students whilst on placement

List of Articles Reviewed in Systematic Review

- 1 McKinley, S., Aitken, L., Doig, G. and Liu, J. (2001). Models of Nursing Education and Training: A systematic review of the literature. National Review of Nurse Education. Sydney, Royal North Shore Hospital.
- 2 Drennan, J. (2002). 'An evaluation of the role of the Clinical Placement Coordinator in student nurse support in the clinical area.' **40**(4): 475.
- 3 Lloyd-Jones, M. and Akehurst, R. (2000). 'Should service providers be paid for providing pre-registration clinical placements?' Journal of Advanced Nursing **32**(2): 432-436.
- 4 Löfmark, A. and Wikblad, K. (2001). 'Facilitating and obstructing factors for development of learning in clinical practice: a student perspective.' Journal of Advanced Nursing **34**(1): 43-50.
- 5 Saarikoski, M., Leino-Kilpi, H. and Warne, T. (2002). 'Clinical learning environment and supervision: testing a research instrument in an international comparative study.' Nurse Education Today **22**(4): 340-349.
- 6 Tang, F., Chou, S. and Chiang, H. (2005). 'Students' perceptions of effective and ineffective clinical instructors.' Journal of Nursing Education **44**(4): 187-192.
- 7 Beitz, J. M. and Wieland, D. (2005). 'Analyzing the teaching effectiveness of clinical nursing faculty of full- and part-time generic BSN, LPN-BSN, and RN-BSN nursing students.' Journal of Professional Nursing **21**(1): 32-45.
- 8 Saarikoski, M. and Leino-Kilpi, H. (2002). 'The clinical learning environment and supervision by staff nurses: developing the instrument.' International Journal of Nursing Studies **39**(3): 259-267.
- 9 Cook, L. J. (2000). The relationships among nursing students' perceptions of inviting teaching behaviors of clinical faculty and students' anxiety during clinical experiences. United States -- Pennsylvania, Widener University School of Nursing.
- 10 Lee, N. J. (2004). 'The impact of international experience on student nurses' personal and professional development.' **51**(2): 113.
- 11 Suen, L. K. P. and Chow, F. L. W. (2001). 'Students' perceptions of the effectiveness of mentors in an undergraduate nursing programme in Hong Kong.' Journal of Advanced Nursing **36**(4): 505-511.
- 12 Andrews, D. S. (2000). Appraisal of clinical teaching behaviours by diploma nursing students and their instructors. Canada, Memorial University of Newfoundland (Canada).
- 13 Tsai, M.-T. and Tsai, L.-L. (2005). 'The critical success factors and impact of prior knowledge to nursing students when transferring nursing knowledge during nursing clinical practise.' Journal of Nursing Management **13**: 459-466.
- 14 Mamchur, C. and Myrick, F. (2003). 'Preceptorship and interpersonal conflict: a multidisciplinary study.' Journal of Advanced Nursing **43**(2): 188-196.
- 15 Lindgren, B., Brulin, C., Holmlund, K. and Athlin, E. (2005). 'Nursing students' perception of group supervision during clinical training.' Journal of Clinical Nursing **14**: 822-829.

- 16 Happell, B. (2002). 'Nursing home employment for nursing students: valuable experience or a harsh deterrent?' Journal of Advanced Nursing **39**(6): 529-536.
- 17 Edwards, H., Smith, S., Courtney, M., Finlayson, K. and Chapman, H. (2004). 'The impact of clinical placement location on nursing students' competence and preparedness for practice.' Nurse Education Today **24**(4): 248-255.
- 18 Adams, V. (2002). 'Consistent Clinical Assignment for Nursing Students Compared to Multiple Placements.' Journal of Nursing Education **41**(2): 80-82
- 19 Lee, W.-S. C., Cholowski, K. and Williams, A. K. (2002). 'Nursing students' and clinical educators' perceptions of characteristics of effective clinical educators in an Australian university school of nursing.' Journal of Advanced Nursing **39**(5): 412-420.
- 20 Arnold, S.-A., Deans, C. and Munday, J. (2004). 'Feature Article University and service sector collaboration for undergraduate psychiatric nursing education.' **13**(1): 61.
- 21 Grant, E. and McKenna, L. 'International clinical placements for undergraduate students.' **12**(4): 529.
- 22 Dolan, G. (2003). 'Assessing student nurse clinical competency: will we ever get it right?' **12**(1): 132.
- 23 Draper, J. and Watson, R. (2002). 'Cadets and nursing students: same destination – different route.' **40**(4): 449.
- 24 Mullen, A. and Murray, L. (2002). 'Clinical placements in mental health: Are clinicians doing enough for undergraduate nursing students?' **11**(1): 61.
- 25 Spouse, J. (2001). 'Bridging theory and practice in the supervisory relationship: a sociocultural perspective.' **33**(4): 512.
- 26 Gray, M. A. and Smith, L. N. (2000). 'The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study.' **32**(6): 1542.
- 27 Langan, J. C. (2003). 'Faculty Practice and Roles of Staff Nurses and Clinical Faculty in Nursing Student Learning.' Journal of Professional Nursing **19**(2): 76-84.
- 28 Grindel, C. G., Bateman, A. L., Patsdaughter, C. A., Babington, L. M. and Medici, G. (2001). 'Student Contributions to Clinical Agencies: A Comparison of Adult Health and Psychiatric Staff Nurses' Perceptions.' Nursing and Health Care Perspectives **22**(4): 197-202.
- 29 Duffy, K. and Watson, H. E. (2001). 'An Interpretive Study of the Nurse Teacher's Role in Practice Placement Areas.' Nurse Education Today **21**(7): 551-558.
- 30 Andrews, G. J., Brodie, D. A., Andrews, J. P., Wong, J. and Thomas, B. G. (2005). 'Place(ment) matters: students' clinical experiences and their preferences for first employers.' International Nursing Review **52**(2): 142-153.
- 31 Begley, C. M. and Brady, A. (2002). 'Irish Diploma in Nursing students' first clinical allocation: the views of nurse managers.' Journal of Nursing Management **10**(6): 339-347.
- 32 Hutchings, A., Williamson, G. R. and Humphreys, A. (2005). 'Supporting learners in clinical practice: capacity issues.' Journal of Clinical Nursing **14**(8): 945-955.
- 33 Calman, L., Watson, R., Norman, I., Redfern, S. and Murrells, T. (2002). 'Assessing practice of student nurses: methods, preparation of assessors and student views.' **38**(5):

516.

- 34 Tuohy, D. (2003). 'Student nurse-older person communication.' Nurse Education Today **23**(1): 19-26.
- 35 Corlett, J. (2000). 'The Perceptions of Nurse Teachers, Student Nurses and Preceptors of the Theory-Practice Gap in Nurse Education.' Nurse Education Today **20**(6): 499-505.
- 36 Chow, F. L. W. and Suen, L. K. P. (2001). 'Clinical Staff as Mentors in Pre-Registration Undergraduate Nursing Education: Students' Perceptions of the Mentors' Roles and Responsibilities.' Nurse Education Today **21**(5): 350-58.
- 37 Davies, S., Gell, L., Tetley, J. and Aveyard, B. (2002). 'Learning to nurse in care homes: student support.' Nursing Standard **17**(13): 39-42.
- 38 Wade, S. and Skinner, A. (2001). 'Student placements in nursing homes.' Nursing Older People **13**(2): 14-7.
- 39 Lopez, V. (2003). 'Clinical teachers as caring mothers from the perspectives of Jordanian nursing students.' International Journal of Nursing Studies **40**(1): 51-60.
- 40 Addis, G. and Karadag, A. (2003). 'An evaluation of nurses' clinical teaching role in Turkey.' Nurse Education Today **23**(1): 27-33.
- 41 Chien, W.-t., Chan, S. W.-c. and Morrissey, J. (2002). 'The use of learning contracts in mental health nursing clinical placement: an action research.' International Journal of Nursing Studies **39**(7): 685-694.
- 42 Rogan, F. and Wyllie, A. (2003). 'Engaging undergraduate nursing students in the care of elderly residents in Australian nursing homes.' Nurse Education in Practice **3**(2): 95-103.
- 43 Evans, B. C. (2003). 'Problems and promises in clinical teaching.' Geriatric Nursing **24**(2): 115-9.
- 44 Lo, R. and Brown, R. (2000). 'A clinical teaching project: evaluation of the Mentor-Arranged Clinical Practice by RN mentors.' Collegian **7**(4): 8-10.
- 45 Remshardt, M. A. (2002). Student perceptions of effective and ineffective clinical faculty teaching behaviors in nursing. United States -- Texas, Texas A&M University - Commerce.
- 46 Wotton, K. and Gonda, J. (2004). 'Clinician and student evaluation of a collaborative clinical teaching model.' Nurse Education in Practice **4**(2): 120-7.
- 47 Kelly, D., Simpson, S. and Brown, P. (2002). 'An action research project to evaluate the clinical practice facilitator role for junior nurses in an acute hospital setting.' Journal of Clinical Nursing **11**(1): 90-98.
- 48 Fisher, J. E. (2002). 'Fear and learning in mental health settings.' International Journal of Mental Health Nursing **11**(2): 128-134.
- 49 Billay, D. B. and Yonge, O. (2004). 'Contributing to the theory development of preceptorship.' Nurse Education Today **24**(7): 566-574.
- 50 Jackson, D. and Mannix, J. (2001). 'Clinical nurses as teachers: insights from students of nursing in their first semester of study.' **10**(2): 270.
- 51 Emberley-Burke, W. J. (2000). The lived experience of the nurse educator during clinical practicum: A phenomenological study. Canada, Memorial University of Newfoundland

(Canada).

- 52 Hsu, L.-L. (2000). A curriculum module for the improvement of clinical teaching in nursing education. United States -- New York, Columbia University Teachers College.
- 53 Dyson, L. (2000). 'The role of the lecturer in the preceptor model of clinical teaching.' Nursing Praxis in New Zealand **16**(3): 16-24.
- 54 Pearson, A., Nay, R., Koch, S., Ward, C., Andrews, C. and Tucker, A. (2001). Australian Aged Care Nursing - A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings. National Review of Nursing Education. Melbourne, LaTrobe University.
- 55 Fitzgerald, M., Pincombe, J., McCutcheon, H., Evans, D., Wiechula, R. and Jordon, Z. (2001). An Integrative Systematic Review of Nursing Curricula Undergraduate Clinical Education and Transition Support to New Graduates. Commissioned by the Queensland Nursing Council and conducted by the Department of Clinical Nursing, Adelaide University in Conjunction with the Joanna Briggs Institute for Evidence Based Nursing and Midwifery. Adelaide.
- 56 Nurses Board of Western Australia Clinical Education for the future - Discussion Paper.
- 57 Saltmarsh, D., North, S. and Koop, T. (2001). Student expectations of Nursing Education. National Review of Nursing Education. Sydney, Macquarie University.
- 58 Clare, J., Brown, D., Edwards, H. and van Loon, A. (2003). Evaluating clinical learning environments: Creating Education - Practice Partnerships and Benchmarks for Nursing. For the Australian Universities Teaching Committee. Adelaide, Flinders University.
- 59 Clare, J. and van Loon, A. (2003). 'Best practice principles for the transition from student to registered nurse.' Collegian **10**(4): 25-31.
- 60 Commonwealth of Australia (2001). Recent Australian Changes to Nurse Education and Training. National Review of Nurse Education. Canberra.
- 61 Nurses Board of Victoria (2002). Review of Aged Care Nursing Component of Undergraduate Nursing Programs. Melbourne.
- 62 de la Rue, M. (2003). 'Preventing Ageism in Nursing Students: An Action Theory Approach.' Australian Journal of Advanced Nursing **20**(4): 8-14.
- 63 Aston, L. and Molassiotis, A. (2003). 'Supervising and supporting student nurses in clinical placements: the peer support initiative.' Nurse Education Today **23**(3): 202-210.
- 64 McCarty, M. and Higgins, A. (2003). 'Moving to an all graduate profession: preparing preceptors for their role.' Nurse Education Today **23**: 89-95.
- 65 Moyles, W. (2003). 'Nursing Students' Perceptions of Older People: Continuing Society's Myths.' Australian Journal of Advanced Nursing **20**(4): 15-21.
- 66 McLeland, A. and Williams, A. (2002). 'An emancipatory praxis study of nursing students on clinical practicum in New Zealand: Pushed to the peripheries.' Contemporary Nurse **12**(2): 185-193.
- 67 Löfmark, A., Carlsson, M. and Wikblad, K. (2001). 'Student nurses' perception of independence of supervision during clinical nursing practice.' **10**(1): 86.
- 68 Lockwood - Rayermann, S. (2003). 'Preceptors, Leadership Style, and the Student Practicum Experience.' Nurse Educator **28**(6): 247-249.

- 69 Lambert, V. and Glacken, M. (2005). 'Clinical education facilitators: a literature review.' Journal of Clinical Nursing **14**: 664-673.
- 70 Landmark, B., Hansen, G., Bjones, I. and Bohler, A. (2003). 'Clinical supervision - factors defined by nurses as influential upon the development of competence and skills in supervision.' Journal of Clinical Nursing **12**: 834-841.
- 71 Grealish, L. (2000). 'The Skills of Coach are an Essential Element in Clinical Learning.' Journal of Nursing Education **39**(5): 231-233.
- 72 Gassner, L., Wotton, K., Clare, J., Hofmeyer, A. and Buckman, J. (1999). 'Theory meets practice - Evaluation of a model of collaboration academic and clinician partnership in the development and implementation of undergraduate teaching.' Collegian **6**(3): 14-28.
- 73 Frieburger, O. (2002). 'Preceptor Programs Increasing Student Self-Confidence and Competency.' Nurse Educator **27**(2): 58-60.
- 74 Fagerberg, I., Winbald, B. and Ekman, S. (2000). 'Influencing Aspects in Nursing Education on Swedish Nursing Students' Choices of First Work Area as Graduated Nurses.' Journal of Nursing Education **39**(5): 211-218.
- 75 Cope, P., Cuthbertson, P. and Stoddart, B. (2000). 'Situating learning in the practice placement.' Journal of Advanced Nursing **31**(4): 850-856.
- 76 Brown, L., Herd, K., Humphries, G. and Paton, M. (2005). 'The role of the lecturer in practice placements: what do students think?' Nurse Education in Practice **5**(2): 84-90.
- 77 Ohrling, K. and Hallberg, R. (2000). 'Student nurses' lived experience of preceptorship. Part 2 - the preceptor-preceptee relationship.' International Journal of Nursing Studies **37**: 25-36.
- 78 Ohrling, K. and Hallberg, I. (2001). 'The meaning of preceptorship: nurses lived experience of being a preceptor.' Journal of Advanced Nursing **33**(4): 530-540.
- 79 Ohrling, K. and Hallberg, R. (2000). 'Student nurses' lived experience of preceptorship. Part 1 - in relation to learning.' International Journal of Nursing Studies **37**: 13-23.
- 80 Papp, I., Markkanen, M. and von Bonsdorff, M. (2003). 'Clinical environment as a learning environment: student nurses' perceptions concerning clinical learning experiences.' Nurse Education Today **23**: 262-268.
- 81 Trevitt, C. (2001). 'Students in Transit: Using a Self-Directed Preceptorship Package to Smooth the Journey.' Journal of Nursing Education **40**(5): 225-228.
- 82 Stockhausen, L. (2005). 'Learning to become a nurse: students' reflections on their clinical experiences.' Australian Journal of Advanced Nursing **22**(3): 8-14.
- 83 Clarke, K. (2005). Undergraduate and Pre Enrolment Nursing Clinical Placements Project. Brisbane, Queensland Health.
- 84 Robinson, A., Venter, L., Andrews, S., Cubit, K., Menzies, B., Jongeling, L., Fassett, M., & Mather, C. (2005). Building Connections in Aged Care: Developing Support Structures for Student Nurses on Placement in Residential Care — Final Report. Hobart, Tasmania, School of Nursing and Midwifery, University of Tasmania
- 85 Abbey, J., Abbey, B., Elder, R., Lemcke, P., Liddle, J. and Thornton, R. (2004). 'Aged Care Clinical Placements through QUT- What works and what does not work Report to Aged Care Queensland.'

- 86 Watkins, M. J. (2000). 'Competency for nursing practice.' **9**(3): 338.
- 87 Reid-Searl, K. and Dwyer, T. (2005). 'Clinical placements for undergraduate nursing students: An educators' guide.' **12**(9): 21.
- 88 Storey, C. and Adams, J. (2002). 'Improving student placements in nursing homes.' Nursing Older People **14**(5): 16-8.
- 89 Landers, M. G. (2000). 'The theory-practice gap in nursing: the role of the nurse teacher.' **32**(6): 1549.
- 90 McKenna, L. G. and Wellard, S. J. (2004). 'Discursive influences on clinical teaching in Australian undergraduate nursing programs.' Nurse Education Today **24**(3): 229-35.
- 91 Lloyd Jones, M., Walters, S. and Akehurst, R. (2001). 'The implications of contact with the mentor for preregistration nursing and midwifery students.' **35**(2): 151.
- 92 Trew, B. (2002). 'Letters... 'Improving student placement in nursing homes' (NOP July 2002).' Nursing Older People **14**(6): 36.
- 93 Sillitoe, C. (2005). 'Students are not used as cheap extra help.' Nursing Times **101**(11): 16.
- 94 McCord, L. and Farmer, E. (2001). 'Student experiences in nursing homes. A response. [comment].' Nursing Older People **12**(10): 33.
- 95 Lumley, J., Calpin-Davies, P. and Mitchell, K. (2000). 'Student experiences in nursing homes: a placement policy gap?' Nursing Older People **12**(8): 14-6.
- 96 Hunsberger, M., Baumann, A., Lappan, J., Carter, N., Bowman, A. and Goddard, P. (2000). 'The synergism of expertise in clinical teaching: An integrative model for nursing education.' Journal of Nursing Education **39**(6): 278-282.
- 97 Ottani, P. A. (2003). 'A balanced perspective of elder Americans: practicum immersion experiences.' Nurse Educator **28**(5): 204-6.
- 98 Chen, S., Melcher, P., Witucki, J. and McKibben, M. A. (2002). 'Nursing home use for clinical rotations: taking a second look.' Nursing & Health Sciences **4**(3): 131-7.
- 99 Chen, S., Witucki, J., Melcher, P. and McKibben, A. (2001). 'Use of nursing homes in baccalaureate nursing education.' Nursing & Health Sciences **3**(1): 57-61.
- 100 Southall, V. H. (2002). 'News, notes & tips. Nursing home buddies: a unique service learning opportunity.' Nurse Educator **27**(3): 101-2.
- 101 McCallum, C. (2004). 'Clinical education in a nursing home setting: a structured framework for student learning... including commentary by Chen S.' International Journal of Therapy and Rehabilitation **11**(8): 374-80.
- 102 Richardson, E., Humphries, B., Fuggle, K., Barber, M., Shepherd, P. and Druce, J. (2001). 'Student placements in the nursing home setting.' Nursing Standard **16**(13-15): 39-44.
- 103 Queensland University of Technology (2004). Aged Care Core Component in Undergraduate Nursing Curricula - Principles Paper. Brisbane, School of Nursing.
- 104 Commonwealth of Australia (2001). National Review of Nursing Education: Discussion Paper. National Review of Nursing Education. Canberra.

- 105 Johnson and Preston An overview of Issues in Nursing Education.
- 106 Commonwealth of Australia (2001). Summary of KPMG Final Report to Nursing Council of New Zealand May 2001: Strategic Review of Undergraduate Education. National Review of Nursing Education. Canberra.
- 107 Commonwealth of Australia (2002). National Review of Nursing Education 2002: Our Duty of Care. National Review of Nursing Education. Canberra.
- 108 Commonwealth of Australia (2002). Recruitment and Retention of Nurses in Residential Aged Care. Canberra.
- 109 National Rural Health Alliance Inc (2004). A quality rural placement system for health students. Australia.
- 110 Nurses Board of Tasmania Supervision of Students in the Practice Setting.
- 111 Haas, B., Deardorff, K., Klotz, L. and Baker, B. (2002). 'Creating a collaborative partnership between academia and service.' Journal of Nursing Education **41**(12): 518-524.
- 112 Lockwood - Rayermann, S. (2003). 'Preceptor Leadership Style and Nursing Practicum.' Journal of Professional Nursing **19**(1): 32-37.
- 113 Farrell, G., Pearson, A. and Roberts, K. (2002). 'The challenges in providing quality clinical education for undergraduate nursing.' Collegian **9**(2): 6-9.
- 114 Elliott, M. (2002). 'Clinical education: a challenging component of undergraduate nursing education.' Contemporary Nurse **12**(1): 69-77.
- 115 Elliott, M. (2002). 'The Clinical Environment: A source of Stress for Undergraduate Nurses.' Australian Journal of Advanced Nursing **20**(1): 34-38.
- 116 Edmond, C. (2001). 'A new paradigm for practice education.' Nurse Education Today **21**: 251-259.
- 117 Burns, I. and Paterson, I. (2005). 'Clinical practice and placement support: supporting learning in practice.' Nurse Education in Practice **5**(1): 3-9.
- 118 Bryant, S. and Williams, D. (2002). 'The Senior Practicum.' Nurse Educator **27**(4): 174-177.
- 119 Yonge, O., Ferguson, L., Myrick, F. and Haase, M. (2003). 'Faculty Preparation for the Preceptorship Experience the Forgotten Link.' Nurse Educator **28**(5): 210-211.
- 120 Parliament of South Australia (2005). Select Committee on Nurse Training and Education. Adelaide.
- 121 Parliament of Australia (2002). The patient profession: Time for action. Canberra.
- 122 Hilton, P. and Pollard, C. (2004). 'Supporting clinical skills developments.' **18**(35): 31.
- 123 Dix, G. and Hughes, S. J. (2004). 'Strategies to help students learn effectively.' Nursing Standard **18**(32): 39.
- 124 Davies, J. and Clarke, D. (2004). 'Clinical skills acquisition in children's nursing: An international perspective.' Paediatric Nursing **16**(2): 23.
- 125 Neill, J. and Taylor, K. (2002). 'Undergraduate Nursing Students' Clinical Experiences in Rural and Remote Areas: Recruitment Implications.' Australian Journal of Rural

Health **10**: 239-243.

- 126 Klang, B. (2003). 'Experiences of clinical education: a Swedish perspective.' *J Interprof Care* **17**(4): 405.
- 127 Iliffe, J. 'RN education has found its level.' *Aust Nurs* **J** **8**(7): 1.
- 128 Spouse, J. (2000). 'An impossible dream? Images of nursing held by pre-registration students and their effect on sustaining motivation to become nurses.' *Journal of Advanced Nursing* **32**(3): 730.
- 129 Johnsen, V. and Barra, J. M. (2002). 'Students' Perceptions of Change.' *Journal of Nursing Education* **41**(8): 357-9.
- 130 Latter, S., Speller, V., Westwood, G. and Latchem, S. (2003). 'Education for Public Health Capacity in the Nursing Workforce: Findings from a Review of Education and Practice Issues.' *Nurse Education Today* **23**(3): 211-18.
- 131 Murray, H. (2001). 'Teaching opportunities in nursing homes.' *Nursing Times* **97**(14): 40.
- 132 Buckis, C. (2003). 'Aged care gets a boost from university and industry partnerships.' *Lamp* **60**(11): 8.
- 133 Davies, S., Powell, A. and Aveyard, B. (2002). 'Mental health nursing. Developing continuing care: towards a teaching nursing home.' *British Journal of Nursing* **11**(20): 1320-8.
- 134 Cook, L. J. (2005). 'Inviting teaching behaviors of clinical faculty and nursing students' anxiety.' *Journal of Nursing Education* **44**(4): 156-161.
- 135 Saxe, J. M., Burgel, B. J., Stringari-Murray, S., Collins-Bride, G. M., Dennehy, P., Janson, S., Humphreys, J., Martin, H. and Roberts, B. (2004). 'What is faculty practice?' *Nursing Outlook* **52**(4): 166-73.
- 136 Schofield, I., Tolson, D., Arthur, D., Davies, S. and Nolan, M. (2005). 'An exploration of the caring attributes and perceptions of work place change among gerontological nursing staff in England, Scotland and China (Hong Kong).' *International Journal of Nursing Studies* **42**(2): 197-209.
- 137 Campbell, S. L. (2005). 'Conceptual model of attractiveness as a factor influencing quality of care and outcomes of residents in nursing home settings.' *Advances in Nursing Science* **28**(2): 107-15.
- 138 Edwards, H., Chapman, H., Forster, E., Gaskill, D., Morrison, P. and Sanders, F. (2003). 'Challenges associated with implementing an education program in a residential aged care setting.' *Australian Health Review* **26**(3): 107-15.
- 139 Gaskill, D., Morrison, P., Sanders, F., Forster, E., Edwards, H., Fleming, R. and McClure, S. (2003). 'University and industry partnerships: lessons from collaborative research.' *International Journal of Nursing Practice* **9**(6): 347-55.
- 140 Kotzabassaki, S., Alabaster, E. S., And, K., Larsson, U. and de Vree, W. (2003). 'Care of older people in nursing homes: an Intensive Programme as an educational activity within Erasmus-Socrates.' *Nurse Education Today* **23**(2): 138-45.
- 141 Birnie, S., Booth, J., Dodd, L., Jones, D., Petty, J., Price, J. and Telford, D. (2003). 'Bridging the gap: addressing the educational needs of nursing home staff.' *Nursing Older People* **15**(2): 14-6.

- 142 Runciman, P., Dewar, B. and Goulbourne, A. (2002). 'Newly qualified Project 2000 staff nurses in Scottish nursing homes: issues for education.' Nurse Education Today **22**(7): 593-601.
- 143 Eastham, K. (2002). 'Out to pasture?' Nursing Older People **14**(2): 32.
- 144 Coombes, R. (2000). 'Oldies but goldies... why students are wrong to think placements in nursing homes are a waste of time.' Nursing Times **96**(37): 14-5.
- 145 Weber, S. (2005). 'Specialized Advanced Clinical Placements for Nurse Practitioner Students.' Journal of the American Academy of Nurse Practitioners**17** (8): 291.
- 146 Miller, J., Shaw-Kokot, J. R., Arnold, M. S., Boggin, T., Crowell, K. E., Allegri, F., Blue, J. H. and Berrier, S. B. (2005). 'A study of personal digital assistants to enhance undergraduate clinical nursing education.' Journal of Nursing Education **44**(1): 19-26.
- 147 Ruckdeschel, K. and Van Hartsma, K. (2004). 'A workshop for nursing home staff: recognizing and responding to their own and resident's emotions.' Gerontology & Geriatrics Education **24**(3): 39-51.
- 148 Sundstrom, H. E. (2000). The characteristics of effective clinical teachers in baccalaureate nursing programs. Unpublished Thesis, Canada, The University of Manitoba (Canada).
- 149 Totin Meyer, M. A. T. (2002). The use of the Principles of Adult Learning Scale to assess the instructional practices of clinical instructors/preceptors for graduate nurse practitioner students in North Carolina. Unpublished Thesis, United States -- North Carolina, North Carolina State University.
- 150 Espeland, V. and Indrehus, O. (2003). 'Evaluation of students' satisfaction with nursing education in Norway.' Journal of Advanced Nursing **42**(3): 226-236.
- 151 Shanley, C. (2004). 'Extending the role of nurses in staff development by combining an organizational change perspective with an individual learner perspective.' Journal for Nurses in Staff Development - JNSD **20**(2): 83-9.
- 152 Smith, S., Edwards, H., Courtney, M. and Finlayson, K. (2001). 'Factors influencing student nurses in their choice of a rural clinical placement site.' Rural and Remote Health **89**.
- 153 Meyer, L., Sedlmeyer, R., Carlson, C. and Modlin, S. (2003). 'A Web Application for Recording and Analyzing the Clinical Experiences of Nursing Students.' Computers, Informatics, Nursing **21**(4): 186-195.
- 154 Meyer, L. (2002). 'Applying the theory of planned behaviour: Nursing students' intention to seek clinical experiences using the essential clinical behaviour database.' Journal of Nursing Education **41**(3): 107-117.
- 155 Leibbrandt, L., Brown, D. and White, J. (2005). 'National comparative curriculum evaluation of baccalaureate nursing degrees: A framework for the practice based professions.' Nurse Education Today **25**(6): 418-429.
- 156 Howard, E. and Steinberg, S. (2002). 'Evaluations of Clinical Learning in a Managed Care Environment.' Nursing Forum **37**(1): 12-20.
- 157 Happell, B. and Brooker, J. (2001). 'Who will look after my Grandmother? Attitudes of Student Nurses Toward the Care of Older Adults.' Journal of Gerontological Nursing **27**(12): 12-17.

- 158 Hand, R. and Thompson, E. (2003). 'Are we really mentoring our students.' AANA Journal **71**(2): 105-108.
- 159 Chan, D. (2002). 'Development of the Clinical Learning Environment Inventory: Using the Theoretical Framework of Learning Environment Studies to Assess Nursing Students' Perceptions of the Hospital as a Learning Environment.' Journal of Nursing Education **41**(2): 69-75.
- 160 Orland-Barak, L. and Wilhelem, D. (2005). 'Novices in clinical practice settings: Student nurses stories of learning the practice of nursing.' Nurse Education Today **25**(6): 455-464.
- 161 Moyes, B. (2004). 'Nursing education and the future.' Collegian **11**(4): 5-6.
- 162 Hyde, A. and Brady, D. (2002). 'Staff nurses' perceptions of supernumerary status compared with rostered service for Diploma nursing students.' Journal of Advanced Nursing **38**(6): 624-632.
- 163 Ellerton, M. (2003). 'Preceptorship the changing face of clinical teaching.' Nurse Educator **28**(5): 200-201.
- 164 Daigle, J. (2001). 'Preceptors in nursing educator: facilitating student learning.' Kansas Nurse **76**(4).
- 165 Clare, J., White, J., Edwards, H. and van Loon, A. (2002). Learning Outcomes and Curriculum Development in Major Disciplines: Nursing - Final Report for the Australian Universities Teaching Committee From a Consortium of School of Nursing, Flinders University, Adelaide, University of Technology, Sydney and Queensland University of Technology, Brisbane.
- 166 Bradshaw, M., Rule, R. and Hooper, V. (2002). 'A Joint Junior-Senior Clinical Experience.' Nurse Educator **27**(2): 56-57.
- 167 Bartz, C. and Dean - Barr, S. (2003). 'Reshaping clinical nursing education: an academic-service partnership.' Journal of Professional Nursing **19**(4): 216-222.
- 168 Andrews, M. and Roberts, D. (2003). 'Supporting student nurses learning in and through clinical practice: the role of the clinical guide.' Nurse Education Today **23**(7): 474-481.
- 169 Theobald, K. and Mitchell, M. (2002). 'Mentoring: Improving Transition to Practice.' Australian Journal of Advanced Nursing **20**(1): 27-33.
- 170 Ogle, K., Bethune, E., Nugent, P. and Walker, A. (2001). Nursing Education and Graduates: Stage 1. National Review of Nursing Education. Geelong, Deakin University.
- 171 Ogle, K., Bethune, E., Nugent, P. and Walker, A. (2002). Nursing and Education: Stage 2. National Review of Nursing Education. Geelong, Deakin University.
- 172 Jones, J. and Cheek, J. (2001). The Scope of Nursing in Australia: A snapshot of the challenges and skills needed. National Review of Nursing Education. Adelaide, University of South Australia.
- 173 Mahnken, J. (2002). Clinical Placements in Victoria: Issues affecting co-ordination in nursing and medical education. Victorian Universities Rural Health Consortium, School of Nursing, Deakin University.
- 174 Robinson, A., Andrews-Hall, S., Fasset, M., Venter, L., Marlow, M., Cubit, K., Menzies, B. & Jongeling, L. (2006). Building Connections in Aged Care Follow-up Evaluation: Final Report. Hobart, Tasmania, School of Nursing and Midwifery, University of

Tasmania.

- 175 Robinson, A., Abbey, J., Toye, C., Barnes, L., Abbey, B., Saunders, R., Lea, E., Hill, O., Parker, D., Roff, A., Andrews-Hall, S., Marlow, A., Venter, L., André, K. (2006). *Modelling Connections in Aged Care: Development of an evidence based/best practice model to facilitate quality clinical placements in aged care - Report on stages 1-3.* Hobart, Tasmania, School of Nursing and Midwifery, University of Tasmania.
- 176 Abbey, J., Abbey, B., Bridges, P., Elder, R., Lemcke, P., Liddle, J. and Thornton, R(2006). 'Clinical placements in residential aged care facilities: the impact on nursing students' perception of aged care and the effect on career plans', *Australian Journal of Advanced Nursing*, **23**, No.4,14-19

Appendices

Only the numbered appendices are printed in this report. Other appendices (indicated by an alpha identifier) are available on request to the first-named author.

Appendix 1: Facility Information Form

Facility Information (Directors of Nursing)

Please circle or write the appropriate response.

1. What is the *total* number of beds in your facility?
 1. LESS THAN 25
 2. 25-50
 3. 51-75
 4. 76-100
 5. MORE THAN 100

2. What percentage of beds in your facility are *high* care beds today? _____ %

3. What percentage of beds in your facility are *low* care beds today? _____ %

4. Please indicate how many of each kind of staff (RN, EN, PCA/ECA/AIN) are employed in your facility today, according to whether they are full time or part time/casual:

	Full time	Part time or casual
a. How many RNs?	_____ (no.)	_____ (no.)
b. How many ENs?	_____ (no.)	_____ (no.)
c. How many PCAs/ECAs/AINs?	_____ (no.)	_____ (no.)

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5. Please indicate the staffing profile (FTE) of your facility during typical morning and afternoon shifts on weekdays and weekends:

	RN	EN	PCA/ECA/AIN
<u>Weekdays</u>			
a. Morning shift	_____ (no.)	_____ (no.)	_____ (no.)
b. Afternoon shift	_____ (no.)	_____ (no.)	_____ (no.)
<u>Weekends</u>			
c. Morning shift	_____ (no.)	_____ (no.)	_____ (no.)
d. Afternoon shift	_____ (no.)	_____ (no.)	_____ (no.)

6. a. Please indicate whether residents in your facility have access to the paramedical, medical and recreational staff listed below (paid for by the facility) and, if 'yes', please indicate for how many hours per week overall.

	NO	UNSURE	YES	If 'yes', how many hours per week?
Diversional therapist	1	2	3	_____ (hrs)
Music therapist	1	2	3	_____ (hrs)
Occupational therapist	1	2	3	_____ (hrs)
Physiotherapist	1	2	3	_____ (hrs)
Dietitian	1	2	3	_____ (hrs)
Speech therapist	1	2	3	_____ (hrs)
General practitioner	1	2	3	_____ (hrs)
Geriatrician	1	2	3	_____ (hrs)
Diabetes educator	1	2	3	_____ (hrs)
Podiatrist	1	2	3	_____ (hrs)

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Hearing specialist	1	2	3	_____ (hrs)
Continence specialist	1	2	3	_____ (hrs)
Psychogeriatric consultant	1	2	3	_____ (hrs)
Wound specialist	1	2	3	_____ (hrs)
Palliative care specialist	1	2	3	_____ (hrs)
Other (please specify)	1	2	3	_____ (hrs)

b. Please indicate what factors influence how often these services are accessed.

- 7.** Please indicate the kind and approximate number of **students/trainees** you had in your facility in the last 12 months.

	NO	UNSURE	YES	NUMBER (ESTIMATE)
1st year nursing students	1	2	3	_____
2nd year nursing students	1	2	3	_____
3rd year nursing students	1	2	3	_____
Honours nursing students	1	2	3	_____
EN nursing students	1	2	3	_____
Certificate III & IV students	1	2	3	_____
Diversional therapy	1	2	3	_____
Music therapy	1	2	3	_____

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Occupational therapy	1	2	3	_____
Dietitian	1	2	3	_____
Speech therapy	1	2	3	_____
Medical/General practice	1	2	3	_____
Catering	1	2	3	_____
Geriatrician	1	2	3	_____
Diabetes educator	1	2	3	_____
Podiatrist	1	2	3	_____
Hearing specialist	1	2	3	_____
Continence specialist	1	2	3	_____
Psychogeriatric consultant	1	2	3	_____
Wound specialist	1	2	3	_____
Palliative care specialist	1	2	3	_____
Pharmacy	1	2	3	_____
Therapy assistant trainees	1	2	3	_____
Other (please specify)	1	2	3	_____

8. Please indicate which of the following staff have position descriptions that stipulate that they are able to work with students.

	NO	UNSURE	YES
RNs	1	2	3
ENs	1	2	3
PCAs/ECAs/AINs	1	2	3
Diversional therapists	1	2	3

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Other allied health staff	1	2	3
Other (please specify)	1	2	3
<hr/>			

Thank you for your participation.

Appendix 2: Student Background Information Form

Modelling Connections in Aged Care

Student nurses - background information

Please circle the appropriate response.

1. What is your age?

1. 17-25 YEARS
2. 26-30 YEARS
3. 30-35 YEARS
4. 36-40 YEARS
5. 41-45 YEARS
6. MORE THAN 45 YEARS

2. Have you previously worked in an aged care facility (i.e. as a carer etc.)?

1. NO
2. YES → **a.** In what capacity did you work?
 1. THERAPY ASSISTANT
 2. EN
 3. ECA/PCA/AIN
 4. CATERING
 5. DOMESTIC STAFF
 6. OTHER (please specify) _____

b. How many years did you work in aged care?

1. LESS THAN 6 MONTHS
2. 6 MONTHS - 1 YEAR
3. 1-5 YEARS
4. 6-10 YEARS
5. MORE THAN 10 YEARS

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- 3.** Have you ever visited a relative in a residential aged care facility?
1. NO
 2. YES

Thank you for your participation.

Appendix 3: RN/EN/PCA Profile Form

Modelling Connections in Aged Care

RN/EN/PCA Profile

Please circle the appropriate response.

- 1.** In what capacity do you work in the aged care facility?
 1. RN
 2. EN
 3. ECA/PCA/AIN

- 2.** How many years have you worked in age care?
 1. LESS THAN 1 YEAR
 2. 1-5 YEARS
 3. 6-10 YEARS
 4. MORE THAN 10 YEARS

- 3.** How many years have you worked in this facility?
 1. LESS THAN 1 YEAR
 2. 1-5 YEARS
 3. 6-10 YEARS
 4. MORE THAN 10 YEARS

- 4.** How many years experience do you have as an RN, EN or ECA/PCA/AIN?
 1. LESS THAN 1 YEAR
 2. 1-5 YEARS
 3. 6-10 YEARS
 4. MORE THAN 10 YEARS

- 5.** What is your age?
 1. LESS THAN 20 YEARS

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2. 20-25 YEARS
3. 26-30 YEARS
4. 30-35 YEARS
5. 36-40 YEARS
6. 41-45 YEARS
7. 46-50 YEARS
8. MORE THAN 50 YEARS

6. What qualification/s do you have?

You may circle more than one response.

1. CERTIFICATE II
2. CERTIFICATE III
3. CERTIFICATE IV
4. EN MEDICATION ENDORSED
5. AAIN/ MEDICATION ENDORSED
6. RN HOSPITAL TRAINED (CERTIFICATE OR DIPLOMA)
7. DIPLOMA OF NURSING (UNDERGRADUATE)
8. BACHELOR OF NURSING (UNDERGRADUATE)
9. POSTGRADUATE CERTIFICATE - GERONTOLOGY
10. POSTGRADUATE CERTIFICATE - PALLIATIVE CARE
11. POSTGRADUATE CERTIFICATE - CONTINENCE
12. POSTGRADUATE CERTIFICATE - MANAGEMENT
13. POSTGRADUATE CERTIFICATE - OTHER

➔ Please specify: _____

14. POSTGRADUATE DIPLOMA - GERONTOLOGY
15. POSTGRADUATE DIPLOMA - PALLIATIVE CARE
16. POSTGRADUATE DIPLOMA - CONTINENCE
17. POSTGRADUATE DIPLOMA - MANAGEMENT
18. POSTGRADUATE DIPLOMA - OTHER

➔ Please specify: _____

19. MASTER DEGREE ➔ Please specify: _____

20. OTHER ➔ Please specify: _____

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7. Do you have any prior training to act as a support person to students or other staff?

1. NO
2. YES ➔ Please specify: _____

8. With whom have you previously worked as a support person?

You may circle more than one response.

1. ECA/PCA/AIN
2. STUDENT ENROLLED NURSE
3. 1ST YEAR STUDENT NURSE
4. 2ND YEAR STUDENT NURSE
5. 3RD YEAR STUDENT NURSE
6. RE-ENTRY RN
7. NEWLY GRADUATED RN
8. NEWLY GRADUATED EN

9. TAFE STUDENTS UNDERTAKING CERTIFICATE II, III OR IV
10. OTHER ➔ Please specify: _____

Thank you for your participation.

Appendix 4: Student Orientation Form

Orientation Checklist – Students

Please tick the appropriate response

During orientation to the facility:

	YES	UNSURE	NO
▪ Was there a formal orientation program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Did one person coordinate your orientation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you introduced to:			
○ the Director of Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Other RNs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Ens?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ ECAs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Domestic & catering staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Reception staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you shown where to put your bag?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you shown where the toilets are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you shown the tea room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told how the shift would be organised – routines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told when and where to have meal breaks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what to do in the event of fire or emergency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what to do in an emergency situation with a resident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you shown where the fire exits are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what to do when the phone rings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what the smoking policy is?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES	UNSURE	NO
▪ Were you told where to access computing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what books/resources are available & where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what times the shifts finish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what time the shifts start?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what to do if you are running late or can't work that shift?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Were you told what to do if you feel sick on a shift & need to go home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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- | | | | | |
|---|---|--------------------------|--------------------------|--------------------------|
| ▪ | Were you told what to do if you need to go home early? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ | Were you told what to if you are feeling anxious or upset? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ | Were you told who to contact if you hurt yourself? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ | Were you told where to access a telephone to make a call? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ | Were you given an orientation to the unit/area (walk around)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ | Were you given an overview of manual handling and lifting policy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ | Did you get the feeling that the staff were expecting you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ | Was the role of RNs in the aged care facility what you expected? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Appendix 5: Mentor Orientation Form

Orientation Checklist – RNs/ENs/AINs

Please tick the appropriate response

During orientation of students to the facility:

	YES	UNSURE	NO
▪ Is there a formal orientation program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Does one person coordinate student orientation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Are students introduced to:			
○ the Director of Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Other RNs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Ens?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ ECAs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Domestic & catering staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Reception staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students shown where to put their bag?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students shown where the toilets are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students shown the tea room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told how the shift would be organised – routines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told when and where to have meal breaks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do in the event of fire or emergency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do in an emergency situation with a resident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students shown where the fire exits are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do when the phone rings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what the smoking policy is?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told where to access computing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what books/resources are available & where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what times the shifts finish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what time the shifts start?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do if they are running late or can't work that shift?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do if they feel sick on a shift & need to go home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do if they need to go home early?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do if they are feeling anxious or upset?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told who to contact if they hurt themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told where to access a telephone to make a call?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students given an orientation to the unit/area (walk around)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendices

- Students given an overview of manual handling and lifting policy? ☐ ☐ ☐

Appendix 6: DON Orientation Form

Orientation Checklist – DONs

Please tick the appropriate response

With regard to orientation of students to the facility, does your preceptor/ policy have the following, or do they cover the following issues?:

	YES	UNSURE	NO
▪ Is there a formal orientation program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Do you have a contact person in the facility for students?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Does one person coordinate student orientation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Are students introduced to:			
○ the Director of Nursing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Other RNs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Ens?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ ECAs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Domestic & catering staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
○ Reception staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students shown where to put their bag?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students shown where the toilets are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students shown the tea room?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told how the shift is organised – routines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told when and where to have meal breaks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do in the event of fire or emergency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do in an emergency situation with a resident?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students shown where the fire exits are?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do when the phone rings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what the smoking policy is?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told where to access computing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what books/resources are available & where?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what times the shifts finish?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what time the shifts start?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do if they are running late or can't work that shift?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do if they feel sick on a shift & need to go home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do if they need to go home early?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told what to do if they are feeling anxious or upset?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Students told who to contact if they hurt themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendices

- Students told where to access a telephone to make a call? ☐ ☐ ☐
- Students given an orientation to the unit/area (walk around)? ☐ ☐ ☐
- Students given an overview of manual handling and lifting policy?
☐ ☐ ☐

Appendix 7: Nominal Group Questions

Student Nominal Group Questions

1. What were your main feelings on the first day?
2. What were your main feelings on the last day?
3. What were the most important things that helped you settle in?
4. What were the major barriers to you settling in?
5. What were the most important things your preceptors did to make you feel you could reach your learning objectives?
6. What showed you that staff were aware of what tasks and roles you could undertake on prac?
7. What sort of activities did you engage in while on placement in the aged care facility?
8. What kind of experiences were you hoping for?
9. What percentage of time did you work with the same mentor? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
10. How much time did you spend with RNs? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
11. How much time did you spend with ENs? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
12. How much time did you spend with AINs? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
13. What were your main feelings with working with residents?
14. What were your most difficult aspects in working with residents?
15. What aspects of this placement contributed to your development as a nurse?
16. What were the least useful aspects of your clinical placement that contributed to your learning?
17. What do you think RNs do in an aged care facility?

Mentor Nominal Group Questions

1. What were the most important things that you did to help students settle in?
2. What were the main barriers to helping students settle in?
3. What were the most important things you did to make students feel they could reach their learning objectives?
4. What were the main barriers to ensuring that students could reach their learning objectives?
5. How much time did you spend with the students? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
6. How much time did the students spend with an RN? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
7. How much time did the students spend with an EN? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
8. How much time did the students spend with an AIN? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
9. What percentage of time did you work with the same student? [0-20%, 21-40%, 41-60%, 61-80%, 81-100%]
10. What sort of activities did the students you mentored engage in while on placement in the aged care facility?
11. What were the main things you did to prepare students for working with residents?
12. What did you think were the most difficult aspects for students working with residents?
13. What were the main strategies used to supervise students?
14. What were the main barriers to effective supervision of students?
15. What were the main benefits of having students in the facility?
16. What were the main problems with having students in the facility?

DON Nominal Group Questions

1. Who are the key staff who take responsibility for the students?
2. What are the most important things that you did to help students settle in? / What does your policy set out as a strategy to help students settle in?
3. What are the main needs of students on placement?
4. What are the main costs involved with having students on placement?
5. What are the main ways that student placements are organized?
6. What are the main ways you determine the appropriate number of students?
7. What are the main strategies you used to prepare staff for the arrival of students?
8. What are the main benefits of having students in the facility?
9. What are the main problems with having students in the facility?
10. What are the main strategies

Appendix 8: Focus Group Questions

Student Questions

1. Could you give us your impressions of the placement overall?
2. Could you give us your impressions of the effect of mentorship?
3. Could you give us your impressions of your reaction to residents?

Mentor Questions

1. Could you give us your impressions of students' placements overall?
2. Could you give use your impressions of your experiences mentoring students?

DON Questions

1. Could you give us your impressions of students' placements overall?
2. Could you give us your impressions of your experiences having students on placement in your facility?
3. Who do you talk to at the university about students?
4. If you have other students, e.g. physios, OTs, in what way does your facility have different programs to accommodate this?

Appendix 9: Placement and Activities Draft One Log

Student Instructions for Completing the Supervision and Placement Activities Log

As part of your involvement in this study we would like you to complete this supervisor and placement log as completely as possible. This data will be used to further develop teaching and learning strategies within residential aged care facilities.

For each hour of each day you need to record whom you worked with/ were supervised by and the activities you undertook. Below are two tables providing you with codes to insert into the relevant cells on the log tables. If you were working alone (which will happen), please use the code for working alone or unsupervised.

Record only the predominant supervisor/activity or procedure that you undertook during each hour block i.e. more than 60% of that hour i.e. over half an hour.

Person	Example	Code
Registered nurse D*	Greater than 60% of your time was spent directly working with a RN eg you are participating in the same activity eg you are handing out medications together	101
Registered nurse I*	Less than 60% of your time was spent directly working with a RN i.e. you are not participating in the same activity as the RN, but they are providing you with guidance eg you are showering a resident and the RN is completing a care plan	102
Enrolled nurse D*	Greater than 60% of your time was spent directly working with an EN i.e. you are participating in the same activity eg you are undertaking wound management activities together	103
Enrolled nurse I*	Less than 60% of your time was spent directly working with an EN i.e. you are not participating in the same activity as the EN, but they are providing you with guidance eg you are showering a resident and the EN is making the bed	104
ECA or PCA D*	Greater than 60% of your time was spent directly working with an ECA/PCA eg you are participating in the same activity eg you are handing undertaking manual handling activities	105
ECA or PCA I*	Less than 60% of your time was spent directly working with an ECA/PCA ie you are not participating in the same activity as the ECA/PCA, but they are providing you with guidance eg you are assisting a resident with their meal and the ECA/PAC is feeding another resident	106
Other Health Workers	Working with a physiotherapist, diversional therapist, general practitioner	107
Working alone	Greater than 60% of your hour was spent working without any supervision/guidance eg sitting and doing uni work, preceptor on a break	108
Absent	Did not attend clinical practice	109
Sick leave	Unable to attend clinical practice due to illness/injury (certificate provided)	110
University staff	Working or meeting with a university staff member on this project or working with a clinical teacher in practice	111

*** D represents direct supervision I represents indirect supervision**

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Activity or procedure	Example	Code
Handover	Attending or giving information relating to resident to other staff	201
Hygiene	Shower, bath, sponge, toileting, Dermalux, making beds, preparing clothes	202
Activities of daily living	Ambulation, manual handling, range of movement exercises, assisting resident with meals	203
Diversional therapy	Craft, TV, talking with resident	204
Medication management	Observing or planning delivery of medications (oral, rectal, IV, IMI, SC injections, peg, syringe driver, transdermal)	205
Medication administration	Participating in the delivery of medications (oral, rectal, IV, IMI, SC injections, peg, syringe driver, transdermal)	220
Wound assessment	Observation or participation in undertaking wound assessment or observing wound management	206
Wound management	Participation in wound management (wound field concept, debridement, swabbing, bandaging)	221
Observations	Temp, BP, Pulse, resps, BSL, pulse oxymetry	207
Documentation	Care plans, RCS documents, resident notes, OBS charts	208
University activities	Assignments (including interviewing resident), Bioscience revision	209
Other nursing procedures	Taking bloods, inserting catheter, catheter toilet, nasogastric feeds, oxygen therapy, resident transport	210
Non nursing activities	Mopping floors, stock take, tidying shelves	211
Doing nothing	Waiting for supervision (can't find RN), not knowing what to do, no suitable activities/procedures available	212
Orientation	Activities related to becoming familiar with the facility, policies, protocols,	213
Other activities	Please specify	214

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Research meeting	Attending a meeting associated with this project	215
Absent	Did not attend clinical practice	216
Sick	Unable to attend clinical practice due to illness/injury (certificate provided)	217
Meal break	If meal break is more than 60% of hour block, more than half an hour	218
Physical assessment	Utilising knowledge and skills for physical and health assessments. Utilising assessment forms eg gait assessment, swallow assessment, pain assessment, continence assessment, mobility assessment.	219

Example of completed log:
Table one – what you actually did

Time	Monday			Tuesday			Wednesday			Thursday			Friday		
	Supervisor	Employee	Activity or procedure	Supervisor	Employee	Activity or procedure	Supervisor	Employee	Activity or procedure	Supervisor	Employee	Activity or procedure	Supervisor	Employee	Activity or procedure
0700-0800	RN direct	David	Injections	RN direct	Majory	Drug round	RN direct	David	Attended handover			Away all day sick	EN direct med endorsed	Lisa	Drug round

Table two – what we want recorded

Time	Monday			Tuesday			Wednesday			Thursday			Friday		
	Supervisor	Employee	Activity or procedure	Supervisor	Employee	Activity or procedure	Supervisor	Employee	Activity or procedure	Supervisor	Employee	Activity or procedure	Supervisor	Employee	Activity or procedure
0700-0800	101	102	205	101	101	205	101	102	201	110		217	103	104	207

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Time	Monday			Tuesday			Wednesday			Thursday			Friday		
Week X	Supervisor	Employee	Activity	Supervisor	Employee	Activity	Supervisor	Employee	Activity	Supervisor	Employee	Activity	Supervisor	Employee	Activity
0700-0800															
0800-0900															
0900-1000															
1000-1100															
1100-1200															
1200-1300															
1300-1400															
1400-1500															
1500-1600															
1600-1700															
1700-1800															
1800-1900															
1900-2000															
2000-2100															
2100-2200															
2200-2300															

Appendix 10: Log as Revised for New Projects

The following are the coding cards that include the revisions decided upon by the Research Team from the recommendations derived from the project findings. The code entry cards (not shown here) will retain 30 minute time slots but add a space at the bottom of each day (or over the page) for students to add activities undertaken that were not captured on the card because they took such little time. The Code 'R' was retained because it may be more relevant when a Clinical Supervisor is not present.

Activity	Example	Code	ACTIVITY KEY	CODING
Handover	<i>Receiving or giving information relating to residents to or from other staff during the handover period</i>	201	<p>Record only the predominant activity or procedure that you undertook during each half</p> <p>hour block (ie, more than 50% of the time). If two activities are equally predominant,</p> <p>(eg, both taking 15 mins.) code the one that you see as being of most value.</p>	
Hygiene	<i>Shower, bed bath, sponge, toileting, Dermalux wash, making beds, preparing clothes, oral care</i>	202		
Activities of daily living	<i>Ambulation, manual handling, assisting resident with set up of meals or prostheses/aids (eg. hearing aids)</i>	203		
Feeding	<i>Assisting dependent residents, who are unable to feed themselves, to eat their meals (not the set up of meals-see code 203)</i>	204		
Nutrition	<i>Attending specific nursing tasks with the aim of providing nutrition to residents eg NGT or PEG feeding, supplying nutritional supplement drinks (not the act of feeding patients orally-see code 204)</i>	205		
Pressure area care	<i>Performing pressure area care on residents eg. repositioning, skin care, applying PAC devices</i>	206		
Wound assessment	<i>Observing or participating in wound assessment, including completing wound assessment forms</i>	207		
Wound care	<i>Observing or participating in wound care practices eg. wound dressings</i>	208		

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ACTIVITY CODING KEY

Record only the predominant activity or procedure that you undertook during each half hour block (ie, more than 50% of the time).). If two activities are equally predominant,

(eg, both taking 15 mins.) code the one that you see as being of most value.

Activity	Example	Code
Medication planning	<i>Observing or participating in the planning of delivery of medications (oral, rectal, IV, IMI, SC injections, PEG, syringe driver, transdermal, NGT, topical, eye/ear drops)</i>	209
Medication administration	<i>Observing or participating in the delivery of medications (oral, rectal, IV, IMI, SC injections, PEG, syringe driver, transdermal, NGT, topical, eye/ear drops)</i>	210
Observations	<i>Temp, BP, Pulse, resps, BSL, pulse oximetry</i>	211
Documentation	<i>Care plans, RCS documents (special RACF documentation), resident notes</i>	212
University activities	<i>Assignments (including interviewing resident/ physical assessment set by the university), revision</i>	213
Orientation	<i>Activities related to becoming familiar with the facility, policies, and protocols</i>	214
Debriefing	<i>Includes individual debriefing with Clinical Supervisor or group debriefing with fellow students</i>	215
Facility education	<i>Any educational learning activities, sessions, or programs developed and/ or delivered by the facility</i>	216
Physiotherapy	<i>Participating in physiotherapy. Please specify (eg, providing range of movement [ROM] exercises</i>	217
Massage	<i>Providing massage for a resident. Please specify (eg, hand massage)</i>	218
Diversional therapy	<i>Participating in planned diversional therapy activities with residents (eg. craft, group activities)</i>	219

ACTIVITY CODING KEY

Record only the predominant activity or procedure that you undertook during each half

Activity	Example	Code
Physical assessment	<i>Utilising knowledge and skills for physical and health assessments. Using assessment forms (eg, gait, swallow, pain, continence, or mobility assessment)</i> <i>NB. This activity is not related to an assessment set by the University (Code 214)</i>	220
Behavioural/ cognitive assessment	<i>Utilising knowledge and skills for behavioural or cognitive assessments. Using assessment forms for these kinds of assessments. NB. This activity is not related to an assessment set by the University (Code 214)</i>	221
Communicating with residents as a primary focus	<i>Conversing or delivering information to residents while not performing a nursing related task</i>	222
Communicating with residents' families	<i>Conversing or delivering information to family members of residents, can include communication with the family & resident</i>	223
Attending case conference	<i>Attending resident's case conference</i>	224
Other nursing activities	<i>Include taking bloods, inserting catheter, catheter toilet,, oxygen therapy, urinalysis, resident transport (please specify these). Also include & specify any nursing activities not coded elsewhere.</i>	225
Non nursing activities	<i>Mopping floors, stock take, tidying shelves, kitchen duties, etc. (please specify)</i>	226
Waiting for supervisor or activity	<i>Waiting for supervisor (or can't find), not knowing what to do, no suitable activities/procedures available</i>	227
Meal break	<i>If meal break is more than 50% of half hour block DO NOT NAME A SUPERVISOR</i>	228

hour block (ie, more than 50% of the time). If two activities are equally predominant,

(eg, both taking 15 mins.) code the one that you see as being of most value.

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SUPERVISION CODING KEY

Record only the predominant supervisor that you worked with during each half hour block (ie, more than 50% of the time). If this time is equally divided (eg, 15 mins each) be guided your decision about which activity to code.

DO NOT CODE A SUPERVISOR FOR MEAL BREAKS.

‘DIRECT’ represents direct supervision & ‘INDIRECT’ represents indirect

Supervisor	Example	Code
Registered Nurse DIRECT	<i>More than 50% of your time was spent directly working with a RN. You are participating in the same activity (eg, you are handing out medications together)</i>	101
Registered nurse INDIRECT	<i>More than 50% of your time was spent indirectly working with a RN. You are not participating in the same activity as the RN, but they are providing you with guidance (eg, you are showering a resident and the RN is completing a care plan)</i>	102
Enrolled nurse DIRECT	<i>More than 50% of your time was spent directly working with an EN You are participating in the same activity (eg, you are undertaking wound management activities together)</i>	103
Enrolled nurse INDIRECT	<i>More than 50% of your time was spent indirectly working with an EN. You are not participating in the same activity as the EN, but they are providing you with guidance (eg, you are showering a resident and the EN is making the bed)</i>	104

supervision (ie, Not directly observing you). If you were indirectly supervised by an

RN while working with another health care professional also record an ‘R’ in the

supervisor box. (eg, code 103R- working with EN, while indirectly supervised by RN).

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SUPERVISION CODING KEY

Record only the predominant supervisor that you worked with during each half hour block (ie, more than 50% of the time). If this time is equally divided (eg, 15 mins. each) be guided your decision about which activity to code.

DO NOT CODE A SUPERVISOR FOR MEAL BREAKS.

'DIRECT' represents direct supervision & **'INDIRECT'** represents indirect

Supervisor	Example	Code
ECA/PCA/AIN/carer DIRECT	More than 50% of your time was spent directly working with an ECA/PCA/AIN/carer. You are participating in the same activity (eg, you are undertaking manual handling activities together).	105
ECA/PCA/AIN/carer INDIRECT	More than 50% of your time was spent indirectly working with an ECA/PCA/AIN/carer. You are not participating in the same activity, but they are providing you with guidance eg, you are assisting a resident with a meal and the carer is explaining the resident's meal preferences while sitting with another resident	106
All present for handover.	More than 50% of your time was spent in handover with all other students, all facility nursing/care staff on duty, and a Clinical Supervisor (if you have one). Please specify exceptions (eg, carers did not attend)	107
University staff	More than 50% of your time was spent working or meeting with a University staff member on this project	108
Clinical Supervisor (Individual)	More than 50% of your time was spent working with your Clinical Supervisor individually (ie, one on one)	109
Clinical Supervisor (Group)	More than 50% of your time was spent working with your Clinical Supervisor in a group of students	110
Facility management	More than 50% of your time was spent liaising with or being educated by senior staff members from the facility (not including an RN supervisor when performing nursing activities)	111

supervision (ie, Not directly observing you). If you were indirectly supervised by an

RN while working with another health care professional also record an 'R' in the

supervisor box. (eg, code 103R-working with EN, while indirectly supervised by RN).

Appendices

SUPERVISION CODING KEY

Record only the predominant supervisor that you worked with during each half hour block (ie, more than 50% of the time). If this time is equally divided (eg, 15 mins. each) be guided your decision about which activity to code.

DO NOT CODE A SUPERVISOR FOR MEAL BREAKS.

'DIRECT' represents direct supervision & **'INDIRECT'** represents indirect

Supervisor	Example	Code
Another nursing student - same placement & uni.	<i>More than 50% of your time was spent working alongside this (same placement) student, on the same activity/procedure</i>	112
Another nursing student - not same placement & uni.	<i>More than 50% of your time was spent working alongside this (different placement) student, on the <u>same</u> activity/procedure (not just in same room)</i>	113
Student of another discipline	<i>More than 50% of your time was spent working alongside a student who is studying a discipline other than nursing (eg, physio.) on the <u>same</u> activity or procedure (not just in the same room).</i>	114
Other health care workers	<i>More than 50% of your time was spent working with a physiotherapist, diversional therapist, general practitioner, speech therapist, social worker etc. Please specify.</i>	115
Volunteer	<i>More than 50% of your time spent working alongside a volunteer during a resident centred activity</i>	116
Working alone	<i>More than 50% of your time was spent working without any supervision/guidance (eg, sitting and doing uni work).</i>	117
Sick leave	<i>Unable to attend clinical practice due to illness/injury</i>	118
Absent	<i>Absent for other reason. Please specify.</i>	119

supervision (ie, Not directly observing you). If you were indirectly supervised by an

RN while working with another health care professional also record an 'R' in the

supervisor box (eg, code 103R-working with EN, while indirectly supervised by RN).

Appendices A-Y: Not Printed in This Report

- A. Information Sheets
- B. Consent Forms
- C. Draft Two Log
- D. Panel Review Letter
- E. Panel Review Information Form
- F. Panel Review Consent Form
- G. Panel Review Directions
- H. Panel Review Form
- I. Draft Three Log
- J. Student Demographic Survey
- K. Student Feedback Survey
- L. Student Information Sheet
- M. Student consent Form Used
- N. Information Sheets (for non-attendees of information sessions)
- O. Education Session and Information Sheets
- P. Clinical Supervisor Information Sheet
- Q. Clinical Supervisor consent form
- R. Clinical Supervisor Consent Form
- S. Daily Information Sheet
- T. Student Notification Letter
- U. Flyers
- V. Draft Four Log
- W. Student Education Sessions
- X. CS Check Cards
- Y. Research Assistant Prompt Sheets

References

- Australian Institute of Health and Welfare (AIHW) 2005. Residential aged care in Australia 2003–04: a statistical overview. AIHW cat. no. AGE 43. Canberra: AIHW (Aged Care Statistics Series no. 20).
- Abbey, J., Parker, D., Abbey, B., Jones, J., Robinson, A., Toye, C. and Barnes, L. (2006). Modelling Connections in Aged Care: Clinical Placements for Undergraduate Students in Aged Care – A Systematic Review. Brisbane, Queensland, School of Nursing, Faculty of Health, Queensland University of Technology.
- Abbey, J., Abbey, B., Bridges, P., Elder, R., Lemcke, P., Liddle, J. and Thornton, R (2006). 'Clinical placements in residential aged care facilities: the impact on nursing students' perception of aged care and the effect on career plans', *Australian Journal of Advanced Nursing*, 23, No.4,14-19
- Abbey, J., Elder, R., Thornton, R., Lemcke, P., Liddle, J., Abbey, B., Bridges, P. (2005) 'Clinical Placements in Residential Aged Care Facilities: Their impact on nursing students' attitudes and career plans – a pilot study', *Aged Care Queensland*.
- Abbey, J., Abbey, B., Elder, R., Lemcke, P., Liddle, J. and Thornton, R. (2004). 'Aged Care Clinical Placements through QUT- What works and what does not work: Report to Aged Care Queensland.'
- Chapple, M. & Murphy, R. (1996) The nominal group technique: extending the evaluation of students' teaching and learning experiences. *Assessment and Evaluation in Higher Education* 21(2): 147-159.
- Clare, J., Brown, D., Edwards, H. and van Loon, A. (2003). Evaluating clinical learning environments: Creating Education - Practice Partnerships and Benchmarks for Nursing. For the Australian Universities Teaching Committee. Adelaide, Flinders University.
- Clare, J., White, J., Edwards, H. and van Loon, A. (2002). Learning Outcomes and Curriculum Development in Major Disciplines: Nursing - Final Report for the Australian Universities Teaching Committee From a Consortium of School of Nursing, Flinders University, Adelaide, University of Technology, Sydney and Queensland University of Technology, Brisbane.
- Delbecq, A.L. & Van de Ven, A. H. (1971) A group process model for problem identification and program planning. *Journal of Applied Behavioural Sciences* 7(4): 467-493.
- Delbecq, A.L., Van de Ven, A. H. & Gustafson, D.H. (1975) *Group Techniques for Program Planning: a guide to nominal group and Delphi processes*. Glenview, Illinois: Scott, Foresman & Company.
- Department of Education; Science and Training and Department of Health and Ageing (2002). *National Review of Nursing Education: Literature reviews*. Canberra, Ausinfo.
- Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.
- Happell, B. (2002). 'Nursing home employment for nursing students: valuable experience or a harsh deterrent?' *Journal of Advanced Nursing*, 39(6): 529-536.
- Hogan, W. P. (2004). Review of pricing arrangements in residential aged care. Canberra, Aged Care Price Review Taskforce, Commonwealth Department of Communications, Information Technology and the Arts.

References

- Lloyd-Jones, G., Fowell, S. & Bligh, J. G. (1999) The use of the nominal group technique as an evaluative tool in medical undergraduate education. *Medical Education* 33: 8-13.
- Mastaglia, B., Toye, C., & Kristjanson, L. J. (2003). Ensuring content validity in instrument development: Challenges and innovative approaches. *Contemporary Nurse* 14(3), 281-291.
- Parliament of Australia (2002). The patient profession: Time for action. Canberra.
- Pearson, A., Nay, R., Koch, S., Ward, C., Andrews, C. and Tucker, A. (2001). Australian Aged Care Nursing - A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings. *National Review of Nursing Education*. Melbourne, LaTrobe University.
- Queensland University of Technology (2004). Aged care core component in undergraduate nursing curricula: principles paper. Kelvin Grove, Queensland University of Technology, School of Nursing.
- Richardson, S. and B. Martin (2004). The care of older Australians - a picture of the residential aged care workforce. Adelaide, National Institute of Labour Studies, Flinders University.
- Robinson, A., Andrews-Hall, S., Fasset, M., Venter, L., Marlow, M., Cubit, K., Menzies, B. & Jongeling, L. (2006). Building Connections in Aged Care Follow-up Evaluation: Final Report. Hobart, Tasmania, School of Nursing and Midwifery, University of Tasmania.
- Robinson, A., Venter, L., Andrews, S., Cubit, K., Menzies, B., Jongeling, L., Fassett, M., & Mather, C. (2005). Building Connections in Aged Care: Developing Support Structures for Student Nurses on Placement in Residential Care — Final Report. Hobart, Tasmania, School of Nursing and Midwifery, University of Tasmania
- Robinson, A., Cubit, K., Venter, L., Jongeling, L., Menzies, B., Andrews, A. & Fassett, M. (2004a) 'Building Connections in Aged Care: Developing Support Structures for Student Nurses on Placement in Residential Care — Report on Stage Two, SNM Aged Care Report No. 3. 'Tasmanian School of Nursing, University of Tasmania, Launceston.
- Robinson, A., Cubit, K., Venter, L., Fassett, M. (2004b). 'Building Connections in Aged Care: Developing Support Structures for Student Nurses on Placement in Residential Care — Report on Stage One, TSoN Aged Care Report No. 2.' Tasmanian School of Nursing, University of Tasmania, Launceston.
- Savage, J. (2000). One voice, different tunes: Issues raised by dual analysis of a segment of qualitative data. *Journal of Advanced Nursing*, 31, 1493-1500.
- Streubert, H. J. (1995). Philosophical dimensions of qualitative research. In H. J. Streubert & D. R. Carpenter (Eds). *Qualitative research in nursing* (pp. 1-14). Philadelphia: J. P. Lippincott.